NHS
Greater Manchester

Agenda

Greater Manchester Strategic Commissioning Committee (Public)

Date: 4 November 2026

Time: 14:45pm to 16:45pm

Venue: MS Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	14:45	5 mins	Welcome, Introductions and Apologies received – Attendance Matrix & Terms of Reference on a Page	Verbal Paper	Information	Dame Sue Bailey *Chair*
2.			Declarations of Interest	Paper	Noting	
3.			Minutes, matters arising and actions from previous meeting held on 7 October 2026	Paper	Approval	
Strategic Updates						
4.	 14:50 15:00 15:10 15:20	40 mins	Chief Officers Update Reports: Chief Clinical Officer Report Chief Commissioning Officer Report Chief Reform and Improvement Officer Report Chief Strategy, People and Partnerships Report	Paper	Discussion	 Manisha Kumar, *Chief Medical Officer* Katherine Sheerin, *Chief Commissioning Officer* Nicola Hepburn, *Acting Chief Reform and Improvement Officer* Charlotte Bailey, *Chief Strategy, People and Partnerships Officer*
5.	15:30	10 mins	Performance Report	Paper	Information	Nicola Hepburn, *Acting Chief Reform and Improvement Officer*
6.	15:40	10 mins	Place Outcomes Framework and Oversight Arrangements	Paper	Information	Charlotte Bailey, *Chief Strategy, People and Partnerships Officer*
7.	15:50	10 mins	GM Public Health Network Transformation	Paper	Approval	Charlotte Bailey, *Chief Strategy, People and Partnerships Officer*
8.	16:00	10 mins	FSoD for Expansion of NHS Talking Therapies	Paper	Information	Chris Pimlott, *Head of Mental Health Strategic Commissioning*

9.	16:10	10mins	GM HIV Strategy 2026-30	Paper	Information	Laura French *Consultant in Healthcare Public Health*
10.	16:20	10 mins	SCC Forward Plan	Paper	Information	Dame Sue Bailey *Chair*
For Information						
	16:30	10 mins	Any other business Board Paper Escalations Meeting Reflections	Verbal	Discussion	All
Date and time of next meeting: **Wednesday 2 December 2026, 14:45pm – 16:45pm** **MS Teams**						

Strategic Commissioning Committee Attendance Matrix from April 2026

Key:

Present	
Apologies	
No Explanation	
Attendee as per ToR	
Member as per ToR	
Not a member	

Member	*Title*	*Apr-26*	*May-26*	*Jun-26*	*Jul-26*	*Aug-26*	*Sep-26*	*Oct-26*
Dame Sue Bailey	Non Executive Director (Chair of SCC)							
Rachel Egan	Non Executive Director							
Jackie Njoroge	Deputy Chair/Senior Independent Director							
Leigh Vallance	NHS GM Partner Member							
Manisha Kumar	Chief Clinical Officer							
Katherine Sheerin	Chief Commissioning Officer							
Nicola Hepburn	Chief Reform and Improvement Officer							
Charlotte Bailey	Chief Strategy, People and Partnerships Officer							
Attendee								
Chris Gaffey	Associate Director of Corporate Services							
Ben Squires	Director of Primary Care (deputising for Katherine Sheerin)							
Paul Lynch	Director of Strategy							
Kathy Roe	Chief Finance Officer							
Melissa Maguinnes	Programme Director Commissioning Development							
Chris Gresty	Analytical Lead, Corporate Services, Digital Insight and Intelligence							
Jim Ritchie	Deputy Chief Clinical Officer							
Sam Evans	Corporate Director of Finance – Commissioning & Financial Assurance (deputising for Kathy Roe)							
Warren Heppolette	Prevention Demonstrator Director, GMCA							
Stephen Downs	Deputy Chief Finance Officer				Deputising for Kathy Roe		Deputising for Kathy Roe	
Ed Dyson	Director of Performance, Improvement & Assurance				Deputising for Nicola Hepburn			
David Boulger	Associate Director - Population Health							
Claire Lake	Deputy Chief Medical Officer				Deputising for Manisha Kumar			
Sarah Owen	Associate Director of Nursing Safeguarding							
Sara Owen	Associate Director of Maternity Assurance (ICB/LMNS)							
Rachael Nielsen	Strategic Lead – Population Health							
Adam Shipp	Clinical Director for Womens and Children							
Laura French	Public Health Consultant							
Chris Tyson	Assistant Director of Intelligence (Place & Strategic Intelligence)							
Claire Igoe	Associate Director of Sustainability and Estates							
Claire Smith	Associate Director Nursing & Quality Assurance							
Jo Street	Programme Director- Transition						Deputising for Charlotte Bailey	
Sophie Spilsbury	Acting Director Recovery and Improvement							Deputising for Nicola Hepburn

Terms of Reference on a page

NHS Greater Manchester

Purpose

The purpose of the Strategic Commissioning Committee ('the Committee') is to obtain assurance, on behalf of the Board, that the ICB has the right commissioning strategy and approach, supported by intelligence, which is delivering its quality, performance, population health, and oversight functions in a way that secures continuous improvement, whilst ensuring that the ICB operates as a strategic commissioner.

The Committee will have a strong focus on improvement, prevention, population health and the left-shift as set out in the 10-Year Health Plan.

The Committee will operate within an agreed shared governance model with the People and Resources Committee to ensure clarity of decision flow, avoid duplication, and prevent delays in financial approvals.

Key duties

Strategic Commissioning

- Apply constructive challenge to the strategic commissioning arrangements and make recommendations to the Board or People and Resources Committee regarding procurement, and evaluation of contractual delivery.
- Oversight of development and implementation of the Commissioning Strategy, ensuring this is developed within the resources available.
- Ensure that opportunities for service redesign in line with the Commissioning Strategy are optimised.
- Where proposals fall within approved budgets and the financial scheme of delegation, the Strategic Commissioning Committee will retain decision making responsibility. Where proposals exceed budget or require material financial variation (as set out in the financial scheme of delegation), the People and Resources Committee will scrutinise financial implications and make relevant decisions, or where appropriate, escalate recommendations to the Board.
- Receive assurance on the commissioning processes and decisions across all commissioned services, including:- Primary Care, Hospital and Community Health Services, Specialised Services, Services commissioned from VSCFE providers, NHS GM Place Based Partnerships.

Other key duties:

- Clinical Strategy
- Performance and Planning
- System Oversight
- Continuous improvement
- Digital Strategy
- Population Health
- Data and Intelligence
- Strategic Risks
- Statutory Functions

Other duties

- Apply constructive challenge to the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSE and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.
- Apply constructive challenge to the oversight of EPRR arrangements.

Membership

The membership of the committee shall comprise of the following members:

- Non-executive Director (Chair)
- Non-executive Director (Deputy Chair)
- Non-executive Director
- NHS GM Partner Member
- NHS GM Partner Member
- Chief Clinical Officer
- Chief Commissioning Officer
- Chief Reform and Improvement Officer
- Chief Strategy, People and Partnerships Officer

Only members of the Committee have the right to attend Committee meetings.

Employee Name	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	CoI Date From	CoI Date To
Bailey, Ms. Charlotte Elizabeth	Y			Nil			
Kumar, Dr Manisha	Y	Financial Interest	Outside employment	Salaried GP at the Robert Darbishire Practice - 1 session per week		2004	Ongoing
Kumar, Dr Manisha	Y	Non-financial professional interest	Loyalty interests	Honorary Professor University of Salford		01/05/2023	Ongoing
Kumar, Dr Manisha	Y	Non-financial personal interest	Loyalty interests	Husband has the following roles: • Operations Director - Primary Eye Care Services LTD • Case Examiner – General Optical Council		2021 2019	Ongoing
Roe, Mrs. Kathryn Anne	Y	Non-financial personal interest	Loyalty interests	My son works in the finance department at Tameside and Glossop NHS Foundation Trust.		14/10/2024	Ongoing
Hepburn, Mrs. Nicola	Y	Financial interests	Clinical private practice	From 29 April 2025 I have been an associate clinical nurse assessor for MHS clinical services. MHS often complete work for MIAA. I do not complete any work on behalf of MHS across Greater Manchester or work commissioned by NHS GM. I complete all work via my own personal company outside of my contracted substantive role.		29/04/2025	Ongoing
Hepburn, Mrs. Nicola	Y	Non-financial professional interest	Outside employment	I am a volunteer Clinical Board Advisor for Now Your Talking a talking based National therapy service.		07/10/2025	Ongoing
Sheerin, Mrs. Katherine Mary (Katherine)	Y	Non-financial professional interest	Loyalty interests	Trustee and Deputy Chair of the Board of the The Whitechapel Centre, a charity which works to prevent homelessness and support people who are homeless, operating across the Liverpool City Region.	This is a voluntary role with no remuneration or expenses paid.	01/01/2025	Ongoing
Non-Executive Directors	**Interest Declared**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**CoI Date From**	**CoI Date To**
Bailey, Dr Susan Mary	Y	Financial Interest	Outside employment	Independent NED on the board of KOOTH PLC, a mental health online digital platform. I am remunerated for this work. Neither any members of my family or I hold shares in this PLC		2022	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	Chair of Centre for Mental Health. The centre and myself advocate for better mental health outcomes for all through the delivery of evidenced based policy briefings and lobbying at a national and Regional level		2018	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Outside employment	Council member university of Salford		2016	
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	BEVAN commissioner - Bevan through evidence base support improved health and social care outcomes For the population of Wales.		2014	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Outside employment	Patron of the Foundation for Professionals in Services to Adolescents {FPSA]		2024	Ongoing
Egan, Rachel Mrs	Y			Nil			
Partner Members	**Interest Declared**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**CoI Date From**	**CoI Date To**
Vallance, Leigh	Y	Financial interest	Outside employment	CEO of Bolton Hospice which is part funded by an NHS Grant		2023	Ongoing
Vallance, Leigh	Y	Financial interest	Outside employment	As Chair of Bolton CVS, (a voluntary sector infrastructure body) who are in receipt of NHS funding		Ongoing	

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Minutes

Greater Manchester Strategic Commissioning Committee

Date: 7 October 2026

Time: 14:45pm - 16:45pm

Venue: Microsoft Teams

(Public)

Present	Apologies
In attendance: Dame Sue Bailey (SB) – Non-Executive Director (Chair) Rachel Egan (RE) – Non-Executive Director (Deputy Chair) Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Prof. Manisha Kumar (MK) – Chief Clinical Officer Leigh Vallance (LV) – VCSE Partner Member Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Kathy Roe (KR) - Chief Finance Officer / Acting Deputy Chief Executive Claire Smith (CS) - Associate Director Nursing & Quality Assurance (item 7) Sarah Owen (SO) – Associate Director Maternity (ICB/LMNS) (item 9) Sophie Spilsbury (SS) – Acting Director Recovery and Improvement, deputising for Nicola Hepburn Sam Evans (SE) - Corporate Director of Finance – Commissioning & Financial Assurance Faye Vaughan (FV) – Governance Advisor (Minutes)	Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer

Item No.	Topic	Action
1.	**Welcome, Introductions and Apologies** SB welcomed everyone to the meeting, introductions were made, and the above apologies were noted.	
2.	**Declarations of Interest** SB reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS Greater Manchester. No interests were declared.	
3.	**Minutes from the previous meeting held on Wednesday 2 September 2026** The minutes were accepted as a true record of the previous meeting held on 2	

	September 2026.	
4.	**Chief Officers Update Reports:** <u>Chief Clinical Officer Report:</u> The NHS Greater Manchester Chief Clinical Officer Report provided an update on key clinical governance, quality, patient safety and system improvement matters across the region, emphasising ongoing oversight and assurance activities. MK reported on the following from the report: • Section 29a Programmes: It was explained that WWL, GMMH and the Northern Care Alliance were responding to CQC section 29A improvement programmes. Common themes included leadership, capacity, transformation, patient flow and organisational capacity. It was confirmed that the ICB were working with the providers and would use support where necessary. • Safeguarding capacity: It was reported that most vacancies in the safeguarding team had been recruited to. Work continued to take place to bring the ten teams together with staff establishing their place and portfolio responsibilities. The opioid-stewardship programme was also formally congratulated by the committee for winning an HSJ Patient Safety Award. The committee approved and supported the recommendations from the Clinical Effectiveness and Governance (CEG) report. **The Committee:** • **Noted the contents of the Chief Clinical Officer Report.** • **Approved the items within the report that require Committee approval.** • **Noted the remaining items that have progressed through established governance routes and do not require further Committee decision.** <u>Chief Commissioning Officer Report:</u> The paper set out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate. KS informed the committee that the Northwest individual-funding-request arrangement hosted by NHS Greater Manchester was expected to go live on 1 November 2026. It was identified as an opportunity to create economies of scale and help manage packages that did not fit neatly within conventional IFR arrangements. It was reported that the 12-week public consultation on cardiac and vascular surgery received more than 900 responses and met the requirements for a service change of this scale. Transport, particularly for people travelling from Oldham and surrounding areas was a major theme. It was explained that the team were working with GMCA to prepare the decision-making business case for Board consideration. Bolton NHS FT had issued notice that it would stop providing its specialist HIV service at the end of the financial year after a period of fragility. It was reported that the specialised commissioning team were developing alternative	

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	arrangements, including interim resilience and long-term service continuity. The committee were informed of a joint inspection of Wigan that had been announced. It was confirmed that the locality team would receive support over the coming weeks. The committee also noted the highest possible outcome achieved in the recent joint area inspection in July 2026. **The Committee:** • **Noted the report.** <u>Chief Reform and Improvement Officer Report:</u> The report highlighted the key areas of assurance and oversight from the Reform & Improvement portfolio. The committee were informed that approximately half of the joint controller agreements had been returned, with the remaining practices receiving targeted assurance conversations before a potential cut-off for processing data from organisations that did not complete the required documentation. It was reported that digital facilitators had contacted non-signatories to establish the reasons why they had not yet been signed and provide confidence about how Greater Manchester uses the information. **The Committee:** • **Noted the report and the position as of M5.** <u>Chief Strategy, People and Partnerships Report:</u> The paper informed the committee of the key priorities, risks and mitigations relating to Live Well, Population Health Transformation, Place Partnerships development and Neighbourhood Health plans. CB informed the committee that the place outcomes framework, partnership agreement, staffing model and funding arrangements were progressing through the Executive Committee and would then go to localities for partner sign-off. The arrangements were intended to establish a practical basis for place working while allowing test-and-learn adjustments. It was reported that all localities had returned neighbourhood plans. Initial data packs had been developed and were being enhanced into a live dashboard with more granular geographical information. CB informed the committee that the HIV Strategy for 2026-30 had been written and would be shared for engagement across the system. The committee asked how risks would be mitigated while the risk log and mitigations remained under development. CB explained that mitigations included regular place leadership briefings, Executive Committee oversight involving local-government Chief Executives and Place Leads, regular review through Chief Officer meetings and partnership mobilisation meetings. CB agreed to include more explicit mitigation detail in future reporting. **The Committee:** • **Noted the report.**	

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5.	**Performance Report** This report provided an update on Greater Manchester's progress in achieving NHS operational planning goals and outlined significant risks faced by our providers along with key improvement actions. The elective waiting list remained above plan and presented a material year-end risk, while RTT performance was close to plan but required oversight. It was further reported that four-hour and twelve-hour urgent-care performance remained below plan, with recovery work focused on patient flow and discharge. Mental-health talking-therapy and learning-disability inpatient numbers also remained above plan. SS reported that both mental-health providers and most acute providers were in national oversight segment 3; The Christie was in segment 1, MFT in segment 2 and NCA in segment 4. These ratings formed part of the committees ongoing performance and recovery oversight. It was reported that Greater Manchester had remained in the national top five for the 31-day cancer standard since April and ranked first nationally in June. Diagnostic waiting times and 31-day cancer treatment performance were reported as ranking fourth nationally, while several other standards remained below plan or required continued assurance. An extended leadership session reviewed in-year recovery plans across the key metrics, with further actions established. The committee agreed to note the report, key delivery risks and areas requiring focused system oversight, retaining a partial-assurance position. **The Committee:** • **Noted the report.**	
6.	**5-Year Commissioning Plan Progress and Commissioning Intentions – From the Forward Plan** The committee were made aware that the 27/28 Commissioning Framework was the delivery vehicle for the first year of the 5 year Strategic Commissioning Strategy. The report provided described the key components of the framework and summarised the primary elements. The framework was NHS GMs mechanism to communicate to all providers what would be commissioned differently in 27/28 and what the expectations of providers were. It was explained that the framework was integral to the 27/28 Operational Planning round process and set the direction for providers, to ensure they have a framework to consider when developing their operational plans. It was further reported that the framework builds on four strategic objectives: neighbourhood health and reducing inequalities, prevention and proactive care, system transformation and delivery of statutory duties. It combined strategic direction, specific 2027–28 service changes, implications for provider planning and continued priority work. KS informed the committee that the organisation was ahead of previous planning cycles and would now undertake more detailed discussions with independent,	

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	voluntary and community-sector providers. National planning guidance may require adjustments, but the organisation intended to retain its overall direction. KS explained that a review would assess current capacity and demand for children's community health services, what the model likely required over the next five years and inform an investment strategy. The committee were made aware that the renewed Greater Manchester Children's Board would bring together local authorities, health services, schools and wider partners. MK described children's mental health as a Live Well priority, particularly at the 16–25 transition into education, employment and training. It was reported that Greater Manchester had been selected for the next phase of the Growing Up Well programme, which aimed to support children in schools before needs required specialist CAMHS intervention and national funding had been secured for the Care Together pilot in Rochdale, Stockport and Tameside. The committee supported the framework and requested that voluntary-sector organisations be included in children's mental-health planning. It was suggested that a more detailed joint report could be shared as the stocktake, service reviews and trauma-informed prevention work developed in the future. **The Committee:** • **Noted the content of the framework and supported the approach.**	
7.	**Quality Assurance Process** CS explained that quality assurance required triangulation across contracts, performance, quality, finance, safeguarding, patient safety, regulatory information and patient experience. It was reported that matrix working was intended to produce a consistent, evidence-based view rather than relying on a single metric or isolated concern. The framework placed the experience of people receiving care at its centre. Complaints, participation groups, patient-safety investigations, safeguarding information and other feedback were considered alongside targets and performance data so that commissioning decisions addressed both measurable outcomes and lived experience. Quality Review Meetings and Contract Review Meetings provided forums for provider deep dives, challenge, learning and formal action. Where evidence of improvement is insufficient, it was explained that concerns could be escalated through provider oversight, NHS England reporting and the Strategic Commissioning Committee, including contractual notices where required. It was reported that the team would complete provider dashboards, establish clear thresholds for concern and risk tolerance, continue cross-portfolio implementation and use the MIAA audit to identify gaps and positive assurance. **The Committee:** • **Noted and welcomed the quality-and-safety assurance framework.** • **Provided oversight or challenge on the next steps, including the audit, dashboards and escalation thresholds.**	
8.	**Thirlwall Inquiry**	

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	The Thirlwall Inquiry was published on 15 September 2026 and makes 17 recommendations following its examination of events at the Countess of Chester Hospital. NHS England subsequently issued immediate requirements for NHS Trusts and Integrated Care Boards (ICBs). This paper summarised the findings and immediate requirements, set out the implications for NHS Greater Manchester (NHS GM) and proposed how specialist neonatal assurance would be received through the Regional Assurance Process and Northwest Neonatal Operational Delivery Network (ODN), with system oversight through the NHS GM Maternity & Neonatal Programme. It was explained that none of the 17 recommendations were assigned directly to ICBs, but NHS England's subsequent requirements placed responsibilities on ICBs for board consideration, safeguarding, bereavement care and commissioning oversight of maternity and neonatal services. It was explained that Greater Manchester would use the Northwest Neonatal Operational Delivery Network and the regional assurance process for specialist neonatal implementation. The ICB would also monitor gaps and residual risks through existing quality and contractual mechanisms, with provider concerns moving from Quality Review Meetings to contractual review where they cannot be resolved. It was reported that Thirlwall would be combined with the response to other maternity and neonatal inquiries through the National Maternity and Neonatal Task Force and the anticipated wider improvement programme. Provider assurance would come through the perinatal performance oversight process, with quarterly maternity and neonatal updates to the committee and immediate escalations through established officer reporting. **The Committee:** • **Noted the Inquiry findings and immediate NHS England requirements.** • **Supported the proposed GM assurance approach.** • **Supported quarterly reporting of the GM assurance position through the NHS GM Maternity & Neonatal Programme.** • **Supported escalation of provider-specific risks or gaps in assurance through the established NHS GM Contract Quality Mechanism where required.**	
9.	**SCC Forward Plan** The committee agreed that the forward plan should become a clearer 12-month view showing whether requested items have been scheduled and returned.	
10.	**Any other business** LV raised a concern about reduced current-year hospice funding and the risk to palliative and end-of-life services. The committee agreed that due process must be followed. It was requested that an interim update be provided at November meeting describing the process and timelines. MK noted that LV leadership role with Bolton Hospice created a more substantial conflict-of-interest consideration than simply recording an interest. It was requested that concerns be escalated through the appropriate forum and that conflicted participants should not take part in funding decisions affecting their organisation.	

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	The committee discussed organisation-wide capacity pressures and the need to make specific service-level impacts more visible to the Board. SB identified quality-improvement skills training and trauma-informed training for all staff as priorities, arguing that both could improve patient experience and outcomes while reducing avoidable effort.	

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Actions Log: Strategic Commissioning Committee

No	Date	Section	Details of the issue	Details of action agreed	Action Lead	Completion Date	Status	Further Detail
SCC-07	02/07/2026	5. Chief Officers Update Reports - Chief Reform and Improvement Officer Report	Committee suggestion to collaborate on a system wide action plan.	ED, CL, NH, LV, DB to collaborate on a system wide action plan, including reviewing successful interventions at MFT for scalability and developing targeted quality improvement initiatives. Update to be provided at a future meeting.	Mel Maguinness	TBC	In progress	Claire Lake / Leigh Vallance / David Boulger supporting. 15/10: Clarity is being sought on when this will be shared with the committee.
Completed at Previous Meeting (Audit Trail)								

NHS
Greater Manchester

Chief Clinical Officer Report

November 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Strategic Commissioning Committee

November 2026

Required information	Details
Title of report	Chief Clinical Officer Report
Author	Claire Lake, Deputy Chief Clinical Officer (Medical) Jim Ritchie, Deputy Chief Clinical Officer (Medical-Secondary Care, Chief Clinical Information Officer) Kenny Li, Chief Pharmacist Melissa Maguinness, Director of Integrated Clinical Strategy and Transformation Anita Rolfe, Deputy Chief Clinical Officer (Nursing and Nurse Advisor to the board) Laura French, Public Health Consultant Sarah Owen, Associate Director Maternity Sarah Owen, Associate Director Safeguarding and Nursing Claire Smith, Associate Director Nursing and Quality Assurance Claire Foster, Deputy Chief Pharmacist Kate Provan, Associate Director Clinical Governance and Improvement Jay Mangan, Assistant Director of Elective Recovery and Reform Waseem Khan, Assistant Director Quality and Safety Tina Mistry, Interim Assistant Director Medicines & Pharmacy - Clinical Standards and Population Health Chris Pimlott, Head of Strategic Commissioning
Presented by	Professor Manisha Kumar, Chief Clinical Officer, NHS GM
Contact for further information	Kate.provan@nhs.net
Executive summary	The November Chief Clinical Officer Report brings together clinical governance, quality, patient safety, medicines and system improvement updates across Greater Manchester. It highlights immediate medicines continuity and safeguarding concerns, progress in system assurance and improvement, and strategic and committee risks requiring continued oversight. • Alerts concern the discontinuation of Levemir by 31 December 2026, with 1,011 patients still requiring transition as at October, and safeguarding concerns at LSCFT's Peripheral Houses IPC service, where NHS GM has one resident. • Advice covers migrant health service changes, the Fonagy Review, GIRFT findings, HSSIB learning on interface pathways, Single National Formulary preparation, provider quality concerns, maternity benchmarking and hospice quality visits. • Assurance updates cover Modern Service Framework delivery arrangements, valproate safety, winter flu vaccination and strengthened primary care quality oversight. Achievements include maternity collaboration and improved access to interpretation at Tameside and Glossop.

	• SR1 and SR2 remain above tolerance with partial assurance. Maternity oversight risk has increased to 20, and two new risks concern NCA provider oversight and the perinatal mental health pathway. SCC approval or support is sought for the medicines and clinical governance recommendations specified in the report.
The benefits that the population of Greater Manchester will experience.	NHS GM's statutory quality and clinical governance functions support people across Greater Manchester to experience safe, effective and continuously improving services. Through targeted quality improvement, strengthened oversight and refreshed governance pathways, the system is better able to identify risks earlier, intervene more consistently and reduce unwarranted variation. This directly supports improved experience and outcomes for patients and communities.
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy, including early identification of inequality-related risks in urgent care, mental health, medicines optimisation and system improvement programmes. It supports more consistent governance and escalation, helping to reduce unwarranted variation and strengthen equitable access and outcomes across Greater Manchester.
The decision to be made and/or input sought	The Committee is asked to • Note the contents of the Chief Clinical Officer Report. • Approve the items within the report that require Strategic Commissioning Committee approval. • Note or endorse the remaining items that have progressed through established governance routes and do not require further Committee decision.
How this supports the delivery of the strategy and mitigates the BAF risks	The report supports strategic commissioning through stronger quality oversight, prevention, equitable access and adoption of effective practice. BAF risks SR1 (Population health and inequalities) and SR2 (Quality, clinical governance and safeguarding) improved from 20 in July to 16 in September but remain above the tolerance ceiling of 15; assurance is partial for both. Priorities are measurable outcomes and inequalities evidence for SR1, and consistent operation and impact of quality, safeguarding and maternity controls for SR2. Committee risks have been realigned to CEG and QOM: CEG1 and CEG2 remain at 20, QOM1 (paediatric audiology) at 16, and QOM2 (maternity and neonatal oversight) has increased from 16 to 20 pending confirmation of LMNS arrangements. New risks QOM3 (NCA provider oversight) and QOM4 (perinatal mental health pathway) are each scored 20 and align to SR2. No risks are proposed for de-escalation.
Key milestones	These are set out within the different sections of the report.
Leadership and governance	This paper is presented to Strategic Commissioning Committee and draws together intelligence, assurance updates and

arrangements	recommendations from NHS GM Clinical Effectiveness and Governance groups and related subgroups, the Greater Manchester Medicines Management Group, NHS GM Clinical Policy Audit and Standards Group, the Mental Health Partnership Group, and other established quality and clinical governance routes.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no separate formal engagement specifically on this cover report, as it brings together assurance, oversight and decision items already developed through established NHS GM governance routes. Clinical engagement has taken place through the relevant committees, subgroups and provider oversight arrangements referenced within the paper. Equality, financial, legal and sustainability considerations are reflected within the underlying work and approvals described in the report where relevant.
Financial or Legal Implications;	Financial implications include rising ADHD assessment and Right to Choose pressures, capacity requirements for pathway assurance and improvement, and contractual notice for health services supporting the two planned Stockport hotel closures. Medicines recommendations identify potential savings of approximately £2.8m by year three from best-value biologics and £1.1m annually from targeted deprescribing; savings from the ITP pathway are anticipated but not quantified. These are opportunities, not realised savings. Legal and regulatory implications include statutory quality and safeguarding duties, mandatory funding of NICE technology appraisal recommendations and medicines safety requirements. Relevant implementation, funding and contractual decisions will need to progress through established governance routes; the report does not set out a consolidated financial assessment.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
N	Y	N	N	N	N	Y

Alert

Levemir Discontinuation December 2026

Levemir (insulin detemir) is a long-acting basal insulin used in adults and children with diabetes mellitus to help maintain stable blood glucose levels between meals and overnight.

The planned discontinuation of Levemir supply by 31 December 2026 presents a risk to continuity of diabetes treatment and patient safety. As of October 2026, 1,011 patients remain prescribed Levemir and require timely transition to a clinically appropriate alternative insulin to prevent treatment disruption.

GP practices and NHS trusts have been alerted and advised to prioritise safe and timely patient transitions. A live monitoring dashboard has been developed and shared with practices to support oversight, track progress and identify outstanding patients requiring intervention. Fortnightly progress updates are being provided to Executive leads and Place Clinical Directors to maintain oversight and support escalation where required. Monthly position updates will be shared with CEGC until January 2027.

Lancashire and South Cumbria NHS Foundation Trust (LSCFT) Peripheral Houses Individual Packages of Care (IPC) Safeguarding Alert

Significant safeguarding and quality concerns have been identified within the Peripheral Houses Individual Packages of Care (IPC) service operated by Lancashire and South Cumbria NHS Foundation Trust (LSCFT). NHS Greater Manchester has one resident receiving care within the service. Immediate actions have been taken to safeguard affected individuals, including relocation to alternative accommodation and enhanced oversight arrangements. The concerns are being managed through established safeguarding, quality and regulatory processes involving the provider, commissioners, local authority partners and relevant regulators, with ongoing review and assurance activity underway.

Advise

Migrant Health

Greater Manchester has commissioned services in place to deliver a health offer to asylum seeker contingency hotels. The asylum seeker contingency hotels are commissioned by the Home Office, with Serco (Serco is a public services provider delivering government contracts across sectors including healthcare, justice and migration, defence, transport and citizen services) commissioned to provide on the on the ground support. The GM health offer is in place to ensure enhanced health checks have been undertaken, urgent care needs are met and also to provide trauma informed and holistic care to asylum seekers who have often faced profound hardship, trauma and abuse enroute to the UK.

The UK Government (over successive governments) policy has been to reduce the use of contingency hotels.

Greater Manchester has had notification of 2 further hotel closures planned:

- Bredbury Hall, Stockport. Planned closure from 31st December 2026.
- Britania Hotel, Stockport. Planned closure from 31st December 2026.

NHS GM is working through contractual notice for providers of the health offer into these hotels. Please note: the Ashley Hotel, Trafford closed summer 2026

Stakeholders (including NHS GM) will work with Serco around a dispersal plan for each

hotel. Dispersal routes are determined by Serco and the Home Office and are not restricted to within GM. In previous hotel closures, residents have moved to elsewhere in England. There is also the option for Serco to move residents out of hotel accommodation and into dispersed housing.

This means that there are 6 asylum seeker contingency hotels remaining in GM:

- Manchester x 4
- Trafford x1
- Oldham x 1

For these remaining hotels, turnover of residents remains high (people often stay for only a few days at a time) but overall occupancy is low to medium. This means there is room for movement across GM hotels as part of dispersal plans.

Independent Review into Mental Health Conditions, ADHD and Autism: Final Report. (Fonagy Review)

The publication of the Fonagy Review in October 2026 marked a significant shift in national policy for mental health conditions, Attention Deficit Hyperactivity Disorder (ADHD) and autism. The review concluded that long waits for assessment and diagnosis are causing harm and recommended a move towards a more integrated, needs-led model of support, with earlier intervention, clinically informed prioritisation, a "no wrong front door" approach, and access to support based on need rather than diagnosis alone. It also highlighted the importance of reducing over-reliance on specialist NHS pathways and strengthening support across education, local government, social care and community settings.

NHS Greater Manchester has already begun implementing a number of changes that are consistent with these recommendations. Work is underway to improve referral quality, clinical triage, prioritisation and access to non-diagnostic support. Procurement of an all-age Digital Front Door and Adult ADHD Triage Hub is progressing, with implementation anticipated from February 2027. In parallel, work is being undertaken to establish more consistent all-age commissioning standards, improve children and young people's pathways and strengthen interim support arrangements. Guidance has also been developed to help people access a range of non-medical and digital resources while awaiting assessment, supporting a shift towards earlier, needs-based support.

However, significant challenges remain. Rising waiting lists, limited assessment capacity and increasing financial pressures, particularly associated with Right to Choose pathways, continue to impact system sustainability. While the planned pathway developments should improve access, navigation and clinical prioritisation, their effectiveness will depend on the availability of appropriate support across the wider system.

This update reflects the health component of the response only and does not represent a comprehensive Greater Manchester approach to the recommendations of the Fonagy Review. Oversight of this programme of work is provided through the Greater Manchester Mental Health Partnership Group and it has also been considered through wider Greater Manchester chief officer arrangements, recognising the breadth of activity underway across the system. Work is progressing with local authorities and other partners across a number of areas relating to ADHD and autism, although developing a fully integrated, cross-system approach remains challenging.

The next phase of work will therefore need to focus on strengthening support before, during and after assessment, reducing reliance on diagnosis as the primary gateway to help, and developing sustainable arrangements across health, education, social care, local government and the

voluntary, community and social enterprise sector. National implementation guidance is still awaited, but the recommendations of the Fonagy Review are expected to influence future policy and delivery expectations in this area.

Getting it right first time (GIRFT) visit to Greater Manchester

Getting It Right First Time (GIRFT) is a national NHS improvement programme that works with systems and providers to reduce unwarranted variation, improve quality and productivity, and support the adoption of evidence-based best practice.

On 28 September 2026, NHS Greater Manchester hosted a system-wide GIRFT visit involving NHS GM, provider executives, clinical leaders and national GIRFT teams. The visit focused on elective care, urgent and emergency care, cancer and diagnostics.

The visit recognised that Greater Manchester has many examples of effective practice already in place and highlighted the strong collaborative approach demonstrated across NHS GM and provider organisations. There was active engagement from providers throughout the discussions, with a shared commitment to addressing common challenges and accelerating improvement across the system.

A consistent message from GIRFT was that many of the solutions required to improve performance already exist within Greater Manchester and that greater progress could be achieved through reducing unwarranted variation and accelerating the adoption and spread of proven approaches. GIRFT also reinforced a "comply or explain" approach to operational standards and best practice. The discussion acknowledged, however, the significant operational pressures facing organisations, including urgent and emergency care demand, workforce pressures, financial constraints and the challenges of delivering transformation alongside day-to-day operational performance. Whilst there was broad support for the principle of adopting and spreading effective practice at pace, there was recognition that achieving consistent implementation across a large and complex system remains challenging and requires sustained leadership, organisational capacity and continued collaboration between providers and NHS GM.

Key areas of focus included improving utilisation of elective hubs, strengthening patient flow and reducing corridor care, implementing GIRFT operational standards and accelerating delivery of cancer and diagnostic improvement programmes.

In response, NHS GM and providers are working collectively through existing improvement programmes and governance arrangements to identify opportunities for wider adoption of successful models, reduce variation where this adds no value, and strengthen system oversight of delivery and impact. Learning from the visit will be incorporated into ongoing elective care, urgent and emergency care, cancer and diagnostic improvement programmes.

The Committee is asked to note the outcomes and key messages arising from the GIRFT visit.

Health Services Safety Investigations Body (HSSIB) Interim Report: Advice and Guidance and Single Point of Access

The Committee is advised of the publication of the Health Services Safety Investigations Body (HSSIB) interim report examining the patient safety implications of Advice and Guidance (A&G) and Single Point of Access (SPoA) pathways. The report recognises the benefits of timely specialist advice and improved clinical collaboration but identifies patient safety risks where pathways are implemented without sufficient governance, oversight, digital clinical safety

arrangements and clarity of accountability.

A key theme of the report is the increasing expectation placed upon Integrated Care Boards to coordinate, assure and oversee complex interface pathways between primary and secondary care. HSSIB highlights six areas for ICB focus: clinical accountability, escalation processes, digital clinical risk management, interoperability, quality oversight and patient safety monitoring.

Greater Manchester has reviewed the findings and concluded that many of the recommendations align with work already underway through the Elective Recovery Programme, implementation of SPoA pathways, Consultant Connect, interface governance arrangements and the Greater Manchester Care Record.

The report nevertheless provides important learning and reinforces the need to strengthen assurance arrangements as implementation continues. Priority actions for Greater Manchester include strengthening interface governance between primary and secondary care, developing a clinically led audit and evaluation programme, improving visibility of quality and patient safety metrics, clarifying escalation routes where clinical disagreement exists, and strengthening digital clinical safety and incident reporting arrangements. These actions will be considered within future commissioning intentions and the emerging Greater Manchester Digital Strategy

The report also highlights a broader strategic challenge: delivering the level of assurance and oversight expected nationally will require sufficient clinical, analytical, digital and programme capacity across both providers and the ICB. This remains a significant implementation consideration alongside the recommendations themselves.

The Committee is asked to note the publication of the HSSIB interim report and the actions underway across Greater Manchester to strengthen the governance, safety and oversight of Advice and Guidance and Single Point of Access pathways.

Greater Manchester – Implementation of Single National Formulary

Preparatory work is underway across Greater Manchester (GM) to support the implementation of the Single National Formulary (SNF), which aims to facilitate timely and equitable access to new medicines and the implementation of National Institute for Health and Care Excellence (NICE) guidance through standardised formulary categories and digital solutions.

GM ICB will retain local decision-making authority for formulary and medicines management. Work is progressing to align existing classifications with the new SNF categories, with any substantive changes managed through established GM medicines governance arrangements.

The mapping exercise is expected to be completed by 9 December 2026. No changes beyond the alignment of existing categories will be implemented without appropriate engagement with the GM system. A further update will be presented in January 2027, outlining progress, key implications and next steps.

New guidance on the provision of single-sex services and facilities

NHS England has issued new guidance on the provision of single-sex services and facilities following the introduction of the Equality and Human Rights Commission (EHRC) Code of Practice for Services, Public Functions and Associations, which came into force on 5 August 2026. The guidance includes revised requirements for same-sex accommodation for patients and new

guidance on NHS staff facilities, with an emphasis on ensuring decisions are lawful, proportionate, evidence-based and maintain privacy, dignity, safety and respect for all patients and staff. Organisations are expected to review local policies, practices and facilities arrangements and develop plans to address any changes required.

As strategic commissioner, the ICB will seek assurance through existing commissioner-provider oversight arrangements that organisations have reviewed the guidance, assessed its implications locally, and have appropriate implementation plans in place where required. This will include consideration of equality impacts, staff and patient experience, and ongoing monitoring to ensure that implementation remains consistent with legal requirements and NHS values.

Quality Review Meeting (QRM) Updates since last meeting

The joint Quality Review Meeting for Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust considered a range of quality and safety assurance matters, including clinical documentation and record keeping, Emergency Department (ED) medical staffing, interpretation services and winter vaccination arrangements. Tameside reported completion of a Trust-wide review of clinical documentation and record keeping, with improvement actions and formal governance arrangements established through a dedicated task and finish group; the inpatient audit identified overall compliance of 65.2%, with a further re-audit planned for January 2027. The meeting also reviewed ED workforce arrangements against Royal College of Emergency Medicine principles, with identified gaps in consultant establishment, alongside plans for influenza vaccination of eligible long-stay patients and those being discharged to care homes. A further issue raised was critical care/ high dependency unit capacity at Tameside, which the Trust highlighted as an ongoing concern ahead of winter; this was noted by the ICB for consideration with clinical colleagues.

Maternity and Neonatal Programme – Greater Manchester

The Greater Manchester Local Maternity and Neonatal System (LMNS), on behalf of NHS Greater Manchester ICB, has completed the first provider-level assurance exercise against the NHS England Maternity and Neonatal 10 Point Plan across all six GM maternity providers.

A multidisciplinary clinical expert panel was established to review and triangulate provider evidence, providing a consistent and clinically informed approach to assurance. The completed GM submission has undergone quality control by the NHS England North West Regional Maternity Team, which has confirmed satisfaction with the assurance process undertaken and incorporated the GM findings into its wider regional submission to the national team.

This initial submission represents a benchmarking exercise, further detail on the GM position, emerging themes and implications for ongoing oversight will be presented to the December Strategic Commissioning Committee, in line with the agreed forward plan.

Greater Manchester Hospice Quality Visits

A programme of quality visits to Greater Manchester hospices is being undertaken as part of NHS Greater Manchester's wider approach to quality assurance and improvement. The visits will provide an opportunity to engage directly with hospice teams, understand the delivery of care and explore key aspects of patient safety, experience, workforce, culture, safeguarding and governance.

Learning from the programme will help identify and share good practice, support improvement and strengthen collective assurance regarding the quality of hospice care across Greater Manchester.

Assure

Modern Service Frameworks

NHS Greater Manchester is putting in place a coordinated approach to delivering the national Modern Service Frameworks (MSFs). Our model is designed to support the delivery of published and forthcoming MSFs by leveraging established governance structures and clinical leadership. Delivery groups for each MSF will be led by a senior responsible officer, supported by named clinical directors, programme leads and medicines leads.

A common approach to the delivery of each MSF will be taken to allow delivery groups to understand need, assess readiness, commission and plan, assure, deliver, and then measure, learn and improve. This will be delivered though a standard set of products, including a needs and inequalities assessment, a gap and variation analysis, a prioritised action plan, an outcomes dashboard and a benefits-realisation plan. Supporting this approach will be a shared improvement method informed by input from all Chief Officer portfolios, places, providers, the voluntary, community, faith and social enterprise sector, patients, and research partners.

A new MSF Oversight Group, jointly chaired by the Chief Clinical and Chief Commissioning Officers, will coordinate this work and provide assurance across the whole programme, allowing reporting to the Strategic Commissioning Committee and Clinical Effectiveness and Governance Committee. The MSF Oversight Group's draft terms of reference are being finalised with an expectation that this group will initially meet on a monthly basis.

Safe prescribing of valproate medicines

Valproate prescribing remains a key medicines safety priority for NHS Greater Manchester (GM). Valproate is a medicine used primarily to treat epilepsy and bipolar disorder. A National Patient Safety Alert issued in November 2023 required all health systems to implement strengthened regulatory measures to reduce the risk of harm from Valproate, particularly the risk of birth defects and neurodevelopmental disorders associated with exposure during pregnancy, and to ensure compliance with national safety requirements. In response, NHS GM established a system-wide Valproate Working Group reporting through the GM Medicines Safety Group to oversee implementation across primary and secondary care.

A review of GM audit data identified variable compliance with existing Pregnancy Prevention Programme requirements and a lack of clarity regarding professional roles and responsibilities. To address this, a comprehensive GM Valproate Prescribing Guidance, supporting tools, assurance checklists, audit resources, coding guidance and a prescribing dashboard have been developed collaboratively with specialist clinicians and stakeholders across the system. These arrangements provide a consistent framework for the safe initiation, prescribing, monitoring and review of Valproate and support implementation of national Medicines and Healthcare products Regulatory Agency (MHRA) requirements.

Performance data provides assurance that prescribing rates continue to reduce across GM. Between April 2024 and March 2026, Valproate prescribing reduced by 8.8% in females aged 13-54 years, 8.7% in females aged 0-54 years and 10.8% in males aged 0-54 years. Greater Manchester remains one of the lower prescribing systems nationally, and all monitored Valproate indicators demonstrate a sustained improving trend across localities.

Nationally, pregnancies exposed to Valproate have reduced by approximately 91% since 2018.

Within GM, two pregnancies in patients prescribed Valproate were reported between April and September 2024. Detailed multidisciplinary reviews concluded that appropriate counselling, risk discussions and management had been undertaken in accordance with national requirements. No concerns regarding care delivery were identified, and no further pregnancies for patients taking Valproate have been reported since September 2024.

The Committee can therefore take assurance that robust governance arrangements are in place, prescribing rates continue to decline, compliance with national safety requirements is being actively monitored, and a coordinated programme of work is supporting the safe use of Valproate medicines across GM. Planned activity for 2026/27 includes formal implementation of the GM Valproate Guidance and launch of the GM Valproate Dashboard to further strengthen system oversight and patient safety.

Winter flu vaccination

The annual winter flu vaccination programme began for adults at risk, carers and front-line health care workers on 1st October. Vaccination of health care workers is one of the key pillars of health system winter resilience and trusts across GM have already made great strides in rolling out vaccinations to their staff. Four trusts; Manchester University NHS Foundation Trust (MFT), Tameside and Glossop Integrated Care NHS Foundation Trust, Stockport NHS Foundation Trust, and Northern Care Alliance NHS Foundation Trust (NCA) have agreed to support the programme further by providing opportunistic vaccinations for staff from NWAS (the North West Ambulance Service NHS Trust) when they are visiting their emergency departments or other parts of the hospital as part of their work. This flexibility will be vital in achieving the national ambition for flu vaccination coverage for our front-line healthcare workers.

Primary Care Quality Review Meeting

The first Primary Care Quality Review Meeting was held on 23 September 2026, marking an important step in strengthening the ICB's systematic approach to quality and safety oversight across general practice, community pharmacy, dentistry and optometry. The meeting established the foundations for improved triangulation of quality intelligence, identification and escalation of emerging risks and unwarranted variation, and clearer oversight of patient experience and safety. The developing arrangements will build on existing contractual and quality assurance mechanisms, strengthening connectivity between primary care commissioning and quality functions and providing a clearer line of sight through the ICB's quality governance arrangements to SCC

Summary of items considered at CEG (October 2026)

The Clinical Effectiveness and Governance (CEG) Committee considered a wide range of statutory clinical governance and system improvement matters. The discussion reflected both substantive clinical decision-making and the evolving governance context associated with the ICB transition.

This table sets out, for each CEG item:

- The decision being made
- Whether SCC approval is required
- The explicit instruction to SCC, or confirmation where SCC action is not required

Full papers available on request

*NICE TA stands for National Institute for Health and Care Excellence technology appraisal.

Technology appraisal (TA) guidance makes recommendations on the use of new and existing medicines and other treatments within the NHS. The NHS is legally obliged to fund and resource medicines and other treatments recommended by TAs.

Ref	CEG paper/Item	Description	Instruction to SCC
Greater Manchester Medicines Management Group (GMMG) Summary of Decisions of Approval			
11-01	NICE TA166: Mepolizumab for maintenance treatment of uncontrolled chronic obstructive pulmonary disease with raised blood eosinophils Published 17/6/26	Can be used for treatment as an add on maintenance treatment option for adult patients if they are having triple therapy including an inhaled corticosteroid a long-acting beta-2-agonist and a long-acting muscarinic antagonist. Opportunity to use best value biologics and could be cost saving by approximately £2.8M by third year of use. Mepolizumab guidance will be considered alongside NICE TA1142 considering dupilumab, as this is implemented.	Approve addition to GMMMG formulary as a specialist only drug following CEG approval.
11-02	GM Treatment Pathway for Adults with Primary Immune thrombocytopenia (ITP)	GM Treatment Pathway for Adults with ITP has been developed to standardise prescribing, reduce variation, improve equity of access and support use of best value treatments. Cost estimates of approximately £3.6M in GM for patients receiving thrombopoeitin-receptor agonists which are considered in the pathway and are optimised so savings from pathway implementation expected.	Approve publication of pathway following CEG approval and note opportunity for cost saving.
11-03	Medicines Optimisation Guidance for Targeted Deprescribing	Guidance aims to reduce overprescribing and reduce inappropriate polypharmacy in a targeted way and is intended to support delivery by appropriately trained healthcare professionals working within primary care and the wider system. Reduction in volume of selected medicines may release approximately £1.1M annually.	Approve for publication following CEG approval.
11-04	NICE TA1172: Atogepant for treating migraine published 30/06/26	Atogepant can be used as an option for the acute treatment of migraine with or without aura in adults, only if, for previous migraines where at least 2 triptans were tried and they did not work well enough, or, triptans were contraindicated or not tolerated, and nonsteroidal anti-inflammatory drugs (NSAIDs) and paracetamol were tried but did not work well enough. NICE expects that the resource impact of implementing the recommendations in England will be less than £8,700 per 100,000 population.	Approve for addition to the GMMMG formulary for prescribing in all settings in this indication following CEG approval.
11-05	Management of Chronic Obstructive Pulmonary	The update COPD management plan is in line with GOLD 2026, emphasising early diagnosis, prevention of exacerbations, structured review- assess- adjust cycles, and environmentally sustainable inhaler	Approve for publication following CEG approval.

	Disease (COPD)	prescribing. It standardises non-pharmacological care and pharmacological escalation.	
11-06	7-minute briefing: Learning from a Methotrexate-Related Death: Preventing Future Harm	Developed in response to the prevention of future deaths report to support shared learning across GM. Highlights risks associated with methotrexate, and reinforces the importance of early recognition of toxicity and timely escalation of care.	Approve for publication and communication to the system following CEG approval.
11-07	7 Minute Briefing: Learning from a Medication Incident: Rivastigmine Patches	Briefing provides system-wide learning across prescribing, dispensing, administration and transfer of care. Already on GMMMG formulary as a green specialist initiation medication.	Approve for publication and communication to the system following CEG approval.
11-08	Incretin therapies: Overview of recent developments and Greater Manchester formulary, and guidance updates	Communication summarises recent updates to GMMMG formulary and guidance relating to incretin therapies, including glucagon-like peptide-1 (GLP-1) receptor agonists and tirzepatide.	Approve for publication following CEG approval.
11-09	The WHO World Antimicrobial Resistance (AMR) Awareness Week (WAAW) 18-24th November 2026	GMMMG were asked to support a GM plan for WAAW which includes sharing of materials, regional AMR lead facilitated webinar, training and education for prescribers and awareness for the wider public.	Support plan for GM in line with CEG support.
11-10	NICE TA1161: Sotatercept for treating pulmonary arterial hypertension published 03/06/26 Commissioning by NHSE	Add to formulary as a Specialist only (RED) drug in this indication, with links to NICE TA1161.	Note addition to GMMMG formulary as specialist medication.
11-11	NICE TA1162: Nusinersen and risdiplam for treating spinal muscular atrophy published 04/06/26 Commissioning by NHSE	This guidance updates and replaces NICE's technology appraisal guidance on nusinersen (TA588) and risdiplam (TA755) for treating spinal muscular atrophy.	Note addition to GMMMG formulary.

11-12	NICE TA1171: Seladelpar for previously treated primary biliary cholangitis published 24/06/26 Commissioning by NHSE	Seladelpar can be used, within its marketing authorisation, as an option to treat primary biliary cholangitis, including associated pruritus, in adults. Add to formulary as a Specialist only (RED) drug in this indication.	Note addition to GMMMG formulary.
Clinical Effectiveness and Governance Committee Recommendations			
11-13	GM Respiratory Transformation Partnership and related respiratory programmes- site selection and implementation approach.	GM has been selected to participate in the national Respiratory Transformation Partnership (RTP) program, which is supported by NHS England, the Office for Life Sciences, the Health Innovation Network and pharmaceutical partners. The programmes aim to improve asthma and COPD outcomes through earlier intervention, neighbourhood-based care, workforce development, improved access to treatment, and greater use of data and digital tools. As part of planned improved GM working with the pharmaceutical industry there has been a system group established to review implementation of this work and other collaborative working with the pharmaceutical industry to support improved access to clinically effective and innovative treatments, using respiratory as a pilot. Site selection for implementation of projects should be proportionate and aligned to the objectives of each intervention, ensuring opportunities are targeted where they can deliver the greatest benefit. The Pharmaceutical Industry Engagement Advisory Group (PIEAG) will coordinate and oversee the projects ensuring evaluation and opportunity to review for scalability.	SCC is asked to note GM selection for the RTP, approve the terms of reference for the PIEAG and site selection process following CEG approval.
11-14	Mental Health Data / Escalation Processes, Learning from Escalations and Transformation Work	Mental health patients face disproportionately long ED waits, driven by variation in crisis capacity, inpatient flow, discharge delays and data quality. The paper proposes stronger use of the Safety Siren and escalation processes, alongside whole-pathway transformation to provide earlier community alternatives to ED.	SCC is asked to support this work in line with CEG
11-15	Jess's Rule System Update	Jess's Rule strengthens safety-netting, reassessment and escalation in primary care when symptoms persist or worsen. Work across GM includes training, decision-support tools, referral improvements and practice action plans, with 63 of 65 PCNs having submitted plans. The next phase will focus on consistent implementation, evaluation and reducing inequalities for people less able to re-present or advocate for themselves.	SCC is asked to support this work in line with CEG

CEG provided collective clinical assurance across statutory clinical governance responsibilities and supported progression of all items through established governance routes. No issues were identified that required escalation outside existing arrangements, with recommendations progressing to the Strategic Commissioning Committee where formal approval is required.

Achievements

Maternity and Neonatal Programme

Maternal Care Bundle Implementation Event (28 September 2026)

The Greater Manchester Local Maternity and Neonatal System (LMNS), in collaboration with the North West Maternal Medicine Network, hosted a system-wide Maternal Care Bundle (MCB) Implementation Event, bringing together colleagues from maternity, neonatal, ambulance, primary care and specialist services. The event provided an opportunity to share progress across the five MCB elements, highlight developments in regional guidance and pathways, and support consistent implementation across GM. Interactive multidisciplinary workshops focused on improving timely access to thromboprophylaxis and addressing digital and data challenges, enabling partners to identify practical solutions and agree next steps to support implementation and reduce unwarranted variation.

Maternity, Primary Care and Neighbourhood Collaborative (8 October 2026)

GM LMNS hosted the second Maternity, Primary Care and Neighbourhood Collaborative, bringing together colleagues from across maternity, primary care and neighbourhood services to strengthen integrated working and improve continuity of care for women and families. The event focused on shared priorities including implementation of the Maternal Care Bundle, early identification and management of venous thromboembolism risk, the postnatal 6–8-week GP consultation, postnatal care and contraception. Interactive workshops supported multidisciplinary discussion on improving pathways between services, strengthening postnatal support and developing more consistent approaches to care across Greater Manchester.

Tameside and Glossop Integrated Care NHS Foundation Trust (TGICFT) – Innovation to improve access and reduce inequalities

TGICFT has introduced video-on-demand interpretation to improve timely access to interpreting support where increasing demand and reduced availability of face-to-face interpreters had contributed to delays, cancellations, poorer patient experience and rising costs. The technology provides 24/7 access to more than 500 languages plus British Sign Language (BSL), without the need to pre-book, enabling interpreting support to be accessed more readily at the point of care.



The early outcomes provide strong positive learning. The Trust reports 1,388 patient interactions, 298 more than July 2025, delivered at a cost of £12.6k, £5.7k less than July 2025. Video interpretation increased from 5 sessions to 722, while the Trust reports fewer delays and cancellations, less use of inappropriate interpretation solutions and an increased number of consultations suggestive of improved patient experience. The model is estimated to offer a potential annualised saving of £68,400.

Risk

This section of the report provides an update to NHS GM Strategic Commissioning Committee on the key risks across the organisation that are owned by the Chief Clinical Officer.

It includes the latest Board Assurance Framework (BAF) risk/s and the committee risks that are owned by the Chief Clinical Officer

The oversight of the risks seen by the committee will facilitate a wider appreciation of the potential impact on the wider ICB objectives. The committee are asked to critically challenge and note the risks presented.

BAF RISK/S

The BAF risk/s for the Chief Clinical Officer that are considered by this committee is/are:
SR1: Population health and inequalities and SR2 Quality, clinical governance and safeguarding

As these BAF risks are being presented to Committee for the first time, there is no previous Committee-approved position against which to report change. The in-year scores below therefore provide the baseline trend: both risks improved from 20 in July to 16 in September but remain one point above the agreed tolerance ceiling of 15. The requested year-end score is 12, with a long-term target of 8 by March 2028.

SR1 Population health and inequalities

Position: improving in-year, but not yet within tolerance. Strategic direction and delivery foundations have strengthened through the Strategic Commissioning Plan, aligned committee workplans and progress across Live Well, BeCCoR, primary care, frailty and secondary prevention. However, assurance remains partial because measurable outcome, inequality and resource-shift evidence is not yet mature.

Next actions / course correction:

1. recover the delayed September action to agree indicators, baselines, trajectories, tolerances and escalation thresholds;
2. complete risk-owner review and approval of the SR1 assurance dashboard, including evidence sources;
3. strengthen reporting to SCC and Board so it demonstrates impact, dependencies and mitigations rather than activity alone; and
4. clarify escalation where partner capacity or delivery threatens strategic outcomes.

The score should remain at 16 until evidence supports a further reduction in likelihood.

SR2 Quality, clinical governance and safeguarding

Position: improving in-year, but not yet within tolerance. Control maturity is improving through the Provider Oversight Model, stronger escalation routes, revised safeguarding leadership, Chief Clinical Officer reporting and developing maternity assurance. Assurance remains partial while these arrangements are embedded consistently and their impact across all commissioned services is demonstrated.

Next actions / course correction:

1. agree quality assurance metrics and evidence thresholds by November 2026;
2. confirm that the revised safeguarding model is operating consistently, notwithstanding its transition to Complete/BAU;
3. present the first formal maternity and neonatal assurance report and agree its dataset and escalation triggers;
4. embed the Provider Oversight Model across all commissioned services; and
5. continue development of clinical governance and patient safety frameworks through March 2027.

The score should remain at 16 until consistent operation and measurable impact support a lower likelihood assessment.

Conclusion

Committee is asked to note this as the first formal baseline, recognise the in-year improvement from 20 to 16 for both risks, and note that neither risk is yet within tolerance.

SR1 Population health and inequalities

Strategic Risk	SR1 Failure to deliver prevention-led population health improvement and reduce inequalities. There is a risk that NHS Greater Manchester, working with system partners, does not make sufficient progress in shifting resource, leadership focus and delivery towards proactive care, neighbourhood working and prevention. This could result in widening inequalities, avoidable demand on services, poorer outcomes for people and communities, and reduced confidence in delivery of the Strategic Commissioning Plan and wider Greater Manchester Strategy ambitions.		
Strategic Objective	Population health, prevention and reducing inequalities.		
Chief Officer / Committee	Risk owner: Chief Clinical Officer Primary committee: Strategic Commissioning Committee		
Risk Appetite Level	Cautious to open	Risk Tolerance Range (e.g. 5 to 10)	5 to 15

Rationale for Risk Score and Progress made in the quarter

The current risk score remains high, reflecting the scale of change required across Greater Manchester to deliver a measurable shift towards prevention, improve population health outcomes and reduce inequalities. While strategic direction has been agreed, the risk remains above tolerance because delivery requires coordinated action across commissioning, provider organisations, local authorities, neighbourhoods and community partners, alongside sustained system-wide alignment during a period of organisational and service reform.

Progress has been made through approval of the Strategic Commissioning Plan, agreement of strategic objectives and continued development of the strategic commissioning operating model. Year one deliverables have been incorporated into committee workplans, providing greater clarity of ownership and shorter-term indicators of progress. Delivery continues across a number of key programmes, including Live Well, BeCCoR, primary care blueprint implementation, clinical strategy delivery, frailty and secondary prevention. These developments provide stronger foundations for delivery and assurance.

However, there is not yet sufficient evidence of a measurable shift in activity, outcomes, inequalities or resource allocation to support a further reduction in the risk score. The principal drivers of the risk remain the pace and consistency of neighbourhood implementation, the ability to shift investment towards prevention, variable maturity of place-based delivery arrangements, and the challenge of demonstrating measurable improvements in population health and inequalities outcomes. The risk will remain above tolerance until there is clearer evidence that strategic priorities are translating into sustained improvements in outcomes, reductions in inequalities and a demonstrable shift towards prevention-led models of care.

Key Controls

ICB-owned controls

-Delivery of the NHS GM Strategic Commissioning Plan and associated Year 1 deliverables.
-Strategic Commissioning Committee oversight and committee workplans aligned to strategic objectives.
-NHS GM operating model for strategic commissioning, including prioritisation, assurance and escalation arrangements.
-Clinical leadership and programme governance for priority areas including prevention, frailty, secondary prevention and long-term conditions.
-Quality, governance and assurance arrangements which incorporate equity and inequalities as a core consideration.
-Use of population health, quality, activity, finance and inequalities intelligence to support prioritisation, decision-making and assurance.
-Development of a strategic outcomes framework and performance reporting aligned to prevention, neighbourhoods and inequalities.

System controls and dependencies

-Greater Manchester Strategy and wider Integrated Care Partnership strategic framework.
-Live Well programme and neighbourhood health model.
-Place partnership arrangements and place-based delivery plans.
-Public health leadership and collaboration with local authorities and GMCA.
-Primary care, provider, community and VCFSE delivery arrangements.
-Prevention Demonstrator programme and associated learning.

ICB role

As strategic commissioner, NHS Greater Manchester provides prioritisation, system leadership, coordination, escalation and assurance for agreed population health outcomes. Delivery is shared across places, providers, local authorities, primary care, community partners and the VCFSE sector. Delivery risks, dependencies and barriers are escalated through established programme, place and committee governance arrangements where these threaten achievement of strategic objectives.

Gaps in Control or Assurance

The main control gaps relate to alignment between prevention priorities, investment decisions, commissioning and contracting levers, and measurable outcomes. While strategic objectives and delivery programmes are established, there is not yet a sufficiently mature outcomes framework to demonstrate whether investment and commissioning decisions are delivering the intended shift towards prevention and reductions in inequalities. Variable maturity of neighbourhood and place-based delivery arrangements also creates inconsistency in implementation and delivery assurance across Greater Manchester.

Key assurance gaps include the absence of an agreed set of strategic indicators, baselines, trajectories and escalation thresholds to evidence progress against prevention, neighbourhood development and inequalities objectives. Demonstrating progress remains challenging due to the long timescales over which prevention benefits are realised and the difficulty of evidencing outcomes that have been avoided. As a result, assurance is often based on delivery activity rather than measurable impact and outcomes.

Delivery is also dependent on partner capacity and capability, shared intelligence and data, digital maturity, VCFSE sustainability, and the ability to maintain strong clinical, professional and place-based leadership during ongoing organisational reform. Further work is required to strengthen escalation arrangements where system dependencies, partner delivery or capacity constraints threaten achievement of strategic outcomes

Risk Scoring and Tolerance										
Measure	Inherent risk score	May-26	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	5	4	4	4				3	2	Mar-28
Impact	5	5	5	4				4	4	
Risk Level	25	20	20	16				12	8	
Number of Linked Risks on Corporate Risk Register				Low 1–4		Mod 6–12		High 15–25		

Assurance	Assurance Level
Assurance is currently assessed as partial. First-line assurance is provided through programme and portfolio reporting, delivery oversight, performance reporting and monitoring of strategic commissioning priorities. Second-line assurance is provided through Strategic Commissioning Committee oversight, aligned committee workplans, and governance arrangements with place partnerships, public health leaders and Greater Manchester Combined Authority partners. Emerging assurance is also provided through strategic programme reporting and development of outcomes measures linked to prevention, neighbourhood health and inequalities priorities. Third-line assurance is developing through external review, national policy and guidance, public reporting and independent evidence relating to population health and prevention. However, assurance remains partial because there is not yet a fully developed set of agreed indicators, baselines, trajectories and escalation thresholds to demonstrate whether current arrangements are delivering measurable improvements in population health outcomes, reducing inequalities and shifting activity and investment towards prevention-led models of care. The assurance level should remain under review until there is clear evidence that controls are operating effectively and translating into measurable improvements in outcomes, reductions in inequalities, and sustainable shifts in activity and resource allocation towards prevention and neighbourhood-based care.	Partial

Action	Complete/BAU	Delayed	On Track	Problematic	BRAG

No	Action Required	Due Date	Progress	BRAG / Status
1	Agree and implement strategic indicators, baselines, trajectories, tolerances and escalation thresholds.	Sep-26	Initial metrics identified through strategic objectives and year-end deliverables; further work required to agree dashboard owners and reporting frequency.	Delayed
2	Strengthen the route from programme plan and delivery into SCC and Board assurance, including explicit reporting on risks, mitigations, dependencies and escalation.	Nov-26	Committee workplan alignment has started. Further refinement required to ensure papers provide clear assurance rather than activity description.	On Track
3	Clarify ICB-owned controls and system dependencies for Live Well, neighbourhood health, BeCCoR, primary care blueprint and prevention delivery.	Jan-27	Dependencies identified; further work required to agree the escalation route where partner delivery or capacity threatens strategic outcomes.	On Track
4	Implement an SR1 assurance framework/dashboard demonstrating progress against prevention and inequalities outcomes	Sep-26	Draft populated. Requires risk owner review, agreement of scores and confirmation of evidence sources before submission.	On Track

SR2 Quality, clinical governance and safeguarding

Strategic Risk	SR2 Failure to maintain effective quality, clinical governance, and safeguarding arrangements. **Risk:** NHS GM is unable to maintain effective quality, clinical governance and safeguarding arrangements across its own functions and commissioned services. **Cause**: Insufficient system-wide quality oversight, and clinical governance arrangements; inconsistent escalation, learning and improvement processes; variation in safeguarding and maternity assurance across providers and partners; and limited capacity to respond to emerging quality, safety, maternity and safeguarding concerns. **Impact:** Quality, safety, patient experience, maternity and safeguarding risks are not identified, escalated or addressed in a timely way, resulting in avoidable harm, poor outcomes, increased inequalities, regulatory or statutory non-compliance, and reduced public confidence in NHS GM and commissioned services.		
Strategic Objective	Statutory responsibilities; population health and inequalities; system transformation		
Chief Officer / Committee	Risk owner: Chief Clinical Officer Primary committee: Strategic Commissioning Committee		
Risk Appetite Level	Cautious to open	Risk Tolerance Range (e.g. 5 to 10)	5 to 15

Rationale for Risk Score and Progress made in the quarter

The current risk remains high because of the potential impact on patient safety, effectiveness of care, patient experience, safeguarding statutory duties, maternity assurance, provider quality oversight, regulatory compliance, inequalities and public confidence. The national Quality Strategy for NHS-funded care in England reinforces that quality should be the organising principle for NHS activity. Whilst progress has been made, the risk should remain static until there is clearer evidence that revised governance, quality oversight, safeguarding and maternity assurance arrangements are operating consistently and delivering measurable improvements in quality and outcomes.

NHS GM is strengthening its clinical governance approach through a more robust quality management and improvement system. Recent progress includes continued development of the NHS GM Provider Oversight Model, strengthened quality escalation routes, revised safeguarding leadership arrangements, enhanced reporting through the Chief Clinical Officer report, and the development of standalone maternity assurance reporting.

There is increasing evidence of improving control maturity through Quality Review Meetings, Clinical Effectiveness and Governance oversight, LMNS maternity and neonatal assurance arrangements, and Deputy Delegated Safeguarding Partner arrangements. However, assurance remains partial as several controls continue to be embedded and there is not yet consistent evidence that learning from quality concerns is systematically translated into improvement and evaluated for impact across all commissioned services. Significant system pressures also remain, including provider quality concerns, mental health capacity, maternity oversight requirements and statutory safeguarding responsibilities.

Key Controls

Key ICB-owned controls

-NHS GM clinical governance framework, quality management and improvement framework, and associated governance arrangements.
-Strategic Commissioning Committee oversight, supported by the Chief Clinical Officer report and Alert, Advise and Assure framework.
-NHS GM Provider Oversight Model, including Quality Review Meetings, risk stratification, escalation processes and contractual quality oversight.
-Clinical Effectiveness and Governance Committee oversight of clinical effectiveness, quality improvement, audits, learning and assurance.
-Safeguarding governance arrangements, including executive leadership, Deputy Delegated Safeguarding Partner arrangements and statutory reporting processes.
-Maternity and neonatal assurance arrangements, including LMNS oversight, CNST assurance requirements and escalation routes.
-Quality, patient safety, safeguarding, equality and clinical impact assessment processes.
-Use of quality, safety, safeguarding, patient experience and outcomes data to support oversight, escalation and assurance.

Key system controls and dependencies

-Provider quality governance and board assurance arrangements.
-Quality Review Meetings and contractual quality management processes across commissioned services.
-Local safeguarding partnerships and adult safeguarding board arrangements.
-LMNS governance, provider maternity assurance processes and national maternity safety requirements.
-System learning from incidents, investigations, complaints, patient safety events, reviews and external scrutiny processes.
-Regional and national oversight, including regulatory and quality assurance arrangements.

Gaps in Control or Assurance

The main control gaps relate to consistency, capacity and evidence of embedded practice rather than the absence of governance arrangements. While quality, safeguarding, maternity and clinical governance arrangements are established, further work is required to demonstrate consistent application of risk stratification, escalation processes, learning systems and assurance arrangements across all commissioned services and sectors. Assurance remains more mature for some provider oversight routes than others, particularly within non-acute, primary care, independent sector and multi-locality commissioned services.

Key assurance gaps include the absence of an agreed set of indicators and evidence thresholds to demonstrate that quality concerns, incidents, reviews and assurance activity are consistently translated into improvement and evaluated for impact. Evidence remains variable across the three national quality domains of safety, effectiveness and experience, and further work is required to demonstrate consistent oversight of inequalities as a cross-cutting consideration.

Continued assurance is also required regarding the embedding of revised safeguarding governance arrangements, maternity and neonatal assurance processes, and the sustainability of clinical, quality and safeguarding capacity within the agreed operating model. Significant system pressures, including provider quality concerns, mental health capacity, maternity oversight requirements and statutory safeguarding responsibilities, continue to influence the level of residual risk.

Risk Scoring and Tolerance										
Measure	Inherent risk score	May-26	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	5	4	4	4				3	2	Mar-28
Impact	5	5	5	4				4	4	
Risk Level	25	20	20	16				12	8	
Number of Linked Risks on Corporate Risk Register				Low 1–4		Mod 6–12		High 15–25		

Assurance	Assurance Level
First line assurance is provided through operational management of the Clinical Portfolio, quality and safeguarding teams, provider Quality Review Meetings, contractual quality schedules, Chief Clinical Officer reporting to Board and SCC, and internal escalation routes. Reports to Strategic Commissioning Committee provide evidence of active oversight of provider quality concerns, safeguarding developments, maternity assurance, health protection, medicines governance and clinical effectiveness matters. Assurance is currently assessed as partial because, whilst reporting and escalation routes are established, evidence of consistent operation and impact across all commissioned services continues to develop. Second line assurance is provided through Strategic Commissioning Committee, Clinical Effectiveness and Governance arrangements, relevant subgroups, safeguarding partnership routes, LMNS safety assurance arrangements, executive oversight, risk reporting and Board Assurance Framework review. These routes provide collective clinical, professional and system assurance, with escalation to SCC where approval, noting or endorsement is required. Assurance remains partial whilst revised governance, maternity reporting and safeguarding arrangements continue to be embedded and monitored. Third line and external assurance includes NHS England regional oversight, regulatory intelligence, CQC findings, national patient safety and maternity assurance frameworks, safeguarding statutory expectations, external review findings, Audit Committee review of the BAF, and independent reviews where relevant. External assurance supports the continued development of governance and oversight arrangements but also demonstrates that residual risk remains elevated whilst improvement actions are embedded and there is not yet consistent evidence that learning from quality concerns is translated into measurable improvement across commissioned services	Partial

Action	Complete/BAU	Delayed	On Track	Problematic	BRAG

No	Action Required	Due Date	Progress	BRAG / Status
1	Embed the NHS GM Provider Oversight Model across commissioned services, including risk stratification, QRM standards, quality schedules, escalation thresholds and evidence requirements..	Dec-26	The model is being tested through existing oversight arrangements. Further evidence is required to demonstrate consistent application across all commissioned services and measurable improvement following intervention.	On Track
2	Confirm and embed the revised safeguarding governance model, including DDSP arrangements, annual reporting, partnership links and multi-agency escalation processes.	Nov-26	The revised DDSP model was implemented in July 2026 and partners notified. Further evidence is required to demonstrate consistent operation, effective partnership interfaces, and timely escalation and closure of safeguarding actions.	Complete/ BAU
3	Develop and present the first formal maternity and neonatal assurance report to SCC, including frequency, core dataset, escalation triggers, alignment with LMNS, CNST and provider assurance routes, and the future reporting cycle.	Dec-26	Standalone maternity paper planned for SCC with twice-yearly maternity assurance placeholder and updates through the CCO report. Further clarity needed on the final assurance dataset, escalation route and evidence required to support any future reduction in likelihood.	On Track
4	Develop and embed NHS GM's clinical governance, quality management and improvement frameworks, including arrangements for monitoring improvement impact and organisational learning.	Mar-27	Key programme and clinical governance roles have been recruited, horizon-scanning has commenced, and revised quality reporting, governance and assurance arrangements are being developed and implemented through the Clinical Effectiveness and Governance Committee.	On Track
5	Establish and implement quality assurance metircs aligned to the national quality domains of safety, effectiveness and experience, including agreed indicators, reporting thresholds, escalation triggers and evidence requirements to support future risk reduction	Nov-26	Initial evidence has been identified through CCO reports, the Provider Oversight Model and safeguarding and maternity assurance updates. Further work is required to agree the final metrics, reporting cycle and evidence thresholds to support future risk reduction.	On Track
6	Develop and embed NHS GM's patient safety framework, including oversight of patient safety intelligence, learning from incidents and investigations, identification of emerging risks, and evaluation of improvement actions and their impact on patient outcomes.	Mar-27	Patient safety oversight currently operates through the CCO report, provider quality assurance routes and governance arrangements. Further work is required to define a consistent patient safety intelligence framework, reporting arrangements and measures of impact across commissioned services.	On Track

Committee Risks

The Committee risk register contains the following corporate risks for the Chief Clinical Officer.

The four risks currently on the corporate risk register have been reviewed and realigned to the two groups that report directly into SCC which are Clinical Effectiveness and Governance Committee (CEG) and Quality Oversight Meeting (QOM-first meeting held in October 2026). The risks have been renamed accordingly to align.

- CCPL9a- renamed CEG1: Sustainability and resilience of the Clinical and Care Professional Leadership workforce
- CCPL9b- renamed CEG2: Clinical leadership assurance, governance and statutory compliance (including Place assurance)
- QUP25/07/25 renamed QOM1: Paediatric Audiology
- CCPL17 renamed QOM2: Quality oversight and assurance of maternity and neonatal services

CCPL17 – QOM2 was increased in score from 16 to 20 in the last reporting period because future GM LMNS governance, hosting, capacity and accountability arrangements are not yet confirmed- so the likelihood of the risk happening has increased. There is a meeting in November that may mean we are able to reduce this risk.

All of these risks relate to BAF SR2-Quality, clinical governance and safeguarding.

Risk Number	Risk Description	Score	Direction	Last reviewed
Clinical Effectiveness and Governance				
CCPL9a/ CEG1	There is a risk that NHS Greater Manchester ICB does not maintain sufficient, sustainable Clinical and Care Professional Leadership (CCPL) capacity and capability within its established clinical portfolio to fulfil its statutory functions, provide effective strategic commissioning leadership and influence safe, high-quality and clinically credible decision-making across the Greater Manchester system.	**20**	➔	**October 2026**
CCPL9b/ CEG2	There is a risk that clinical advice, challenge and assurance are not consistently embedded in ICB decision making, commissioning and transformation across Greater Manchester during transition to the Model ICB and ongoing financial and organisational change.	**20**	➔	**October 2026**
Quality Oversight Meeting				
QUP25/07/25 - QOM1	There is a risk of limited assurance on the quality of interventions within paediatric audiology services which may cause delayed harm to the CYP population	**16**	➔	**October 2026**
CCPL17/ QOM2	There is a risk that the level of quality oversight and assurance of maternity and neonatal services will reduce in NHS GM which may result in a reduction in the quality and clinical safety of care and poorer outcomes for the people of Greater Manchester.	**20**	↑	**October 2026**

Focus on New Risks
There were 2 new risks presented and approved at CEG in October 2026. Both risks align directly to BAF SR2: Quality, clinical governance and safeguarding. These risks have been to CEG in October 2026 and will be reassigned to the newly established QOM in November 2026.

Risk Number	Risk Description	Score	Direction	Last reviewed
People & Culture				
QOM3	Northern Care Alliance NHS Foundation Trust provider quality and performance oversight: risk of patient harm and poor outcomes arising from the scale of quality, governance, operational and digital improvement required	**20**	**NEW**	**October 2026**
QOM4	Perinatal mental health pathway: risk of serious harm or maternal death following discharge from maternity services where safeguarding involvement or parent–infant separation affects access to specialist support and coordinated care	**20**	**NEW**	**October 2026**

Highlight any De-escalated Risks
There are no risks for de-escalation in this reporting period.

Recommendations:

The Committee is asked to:

- Note the contents of the Chief Clinical Officer Report.
- Approve the items within the report that require Strategic Commissioning Committee approval.
- Note or endorse the remaining items that have progressed through established governance routes and do not require further Committee decision.

Period: March 2026

NHS GM CORPORATE RISK REGISTER

Risk Number	Source	Risk Category	Risk Type	Date risk added	Risk Owner	Risk Description	Inherent Risk Score			Trend	Risk Proximity	Controls	Gaps in Controls	Current Risk Score			Rationale for currenrt risk score	Actions	Progress Against Actions (Optional)	Action Owner	Completion Date for actions	Assurances	Gaps in Assurances	Target Risk Score (anticipated score when mitigation			Functional Area (optional)	Geographical Location (optional)	Last reviewed	Risk Target Date	Open/ Closed	Date and Reasons for Closure
Number to identify risk	*The source of the risk (e.g. Manager, Committee, Board meeting etc..)*	*Alignment to one of 13 risk categories **(for GMPMO to complete)***	*Alignment to one of 3 risk types: 1.Organisation 2.System-wide 3. Both*	*Date when the risk was added to the risk register*	*Job title of the person responsible for the management, monitoring, control and escalation*	*A statement describing the risk event, cause and impact*	Likelihood	Impact	RAG Status	*The trend indicates any change in the current risk score in the form of an arrow*	*Timescale as to when the risk will occur*	*Please describe the controls in place to manage/reduce the risk*	*Please describe any gaps in controls to manage/reduce the risk*	Likelihood	Impact	RAG Status	*Please explain the rationale for the risk score since previousthe update, whether the risk score has increased, decreased or remained static*	*The actions and activities planned to take place that will when implemented or completed reduce, eliminate or minimise the risk*	*Progress updates against actions*	*Job title of the person responsible for completing the action*	*Each action should have a completion date set*	*Please describe the assurance(s) in place to manage/reduce the risk*	*Please describe any gaps in the assurance(s) in place to manage/reduce the risk*	Likelihood	Impact	RAG Status	*A functional area within a regional team or a service area within a directorate*	*Where the risk is attributed to*	*Date when the risk was last reviewed and/or updated*	*Date risk will be mitigated by*	*Select Current Status of Risk*	*Reasons outlining why the risk was closed*
QUP25/07/25 To rename as QOM1 and assign to Quality Oversight Meeting from Nov 2026 onwards	Manager	Quality and Safety	1. Organisation	25/07/2025	**Manisha Kumar, Chief Clinical Officer**	**Risk -** There is a risk of limited assurance on the quality of interventions within paediatric audiology services which may cause delayed harm to the CYP population	4	4	16	↔	0-3 months	National Improvement Programme run from CSO with clear standards and expectations regarding accreditation and training Rapid Quality Review of Stockport FT Paediatric Audiology Provision Commissioner led meeting to review provision and sustainability NHS GM ICB Paediatric Audiology Oversight Group Regional Rapid Quality Review	National CSO Improvement programme is still underway which means the quality of all services is not yet fully understood which reduces the opportunity for mutual aid across the system Subject Matter expert availability is low which impacts the ability to schedule the quality site visits	4	4	16	Whilst all cohort reviews have now been completed and robust oversight arrangements are in place, full assurance has not yet been achieved across all providers. Improvement plans remain in delivery, with ongoing monitoring required to ensure actions are implemented and sustained. Given the potential for significant harm to children and young people should further issues be identified, the consequence remains major and the likelihood remains possible, resulting in a current risk score of 16.	Commission national approved services in line with CSO recommendations Work with national colleagues to support assurance oversight Risk stratification to manage backlog of care where applicable Apply a sustainability lens to understand how commissioning differently may reduce risk and future proof the GM services	All GM Paediatric Audiology site visits completed by 31st July - work underway to analyse intelligence and develop service specific, trust level and GM level action plans 15/10/25 All trusts submitting revised action plans by 20/10/25 in light of improvement work and recommendations from QA visits. Look back reviews commenced for 2 further sites - Salford Site of NCA and WWL. This will determine any further recall which may increase overall risk score depending on numbers impacted. Regular meeting with Trust SLT, exploring mutual aid, exploring the opportunity for sub-contracting of IS provider to assist with	Claire Smith Associate Director of Nursing & Quality Jennie Gammack Programme Director - sustainable services	Set out in narrative in relation to actions	NHS GM Paediatric Audiology Oversight Group in place to oversee progress ICB and the Diagnostics Network are working collaboratively with Stockport Foundation Trust and the NHSE Regional Team to find a solution to the current risk Learning from Stockport FT position is being shared into wider system work Significant progression with the PHSI programme which will enable confidence across GM that reviews have been undertaken where standards have not been met. Incident Management Groups in place to ensure robust scrutiny of the process. Superclinic model approved and being implemented January/February 2026 to address the recall's for Stockport NHS Foundation Trust. 18/03/2026 GM and Regional oversight continues, including the commencement of a North West Regional Harms Review panel. Learning from this is fed back to the individual Trusts and into the national learning from the PHSI programme. 21/05/2026 Ongoing oversight mechanisms in place. Desk top review of all improvement plans has enabled a clear pathway to attaining high assurance for all Trusts and timescales have been reviewed and applied to all actions. 08/09/2026 Continued conversation in relation to iQIPs accreditation and the potential for this to limit assurance. This is happening at a national level. Newly published technical guidance gives more	Lack of Subject Matter Expertise available to ensure timely completion of assurance phase of the CSO Improvement Programme Absence of clear decision making in relation to future service delivery Capacity within the wider system to support via mutual aid 15/10/25 Additional capacity commissioned (Health Harmonie) however this only supports the patient waiting list for SFT at present. Resource/support requested from new pool of subject matter experts from NHSE to address the recall patients. This number	2	4	8	GM	Mar-26	Sep-26	31/03/2027	Open	
CCPL09A To rename CEG1 and to continue to report into Clinical Effectiveness and Governance	NHS GM CEG	Quality and Safety	3. Both	Jan-25	**Manisha Kumar, Chief Clinical Officer**	**Sustainability and resilience of the Clinical and Care Professional Leadership workforce** **Risk** There is a risk that NHS Greater Manchester ICB does not maintain sufficient, sustainable Clinical and Care Professional Leadership (CCPL) capacity and capability within its established clinical portfolio to fulfil its statutory functions, provide effective strategic commissioning leadership and influence safe, high-quality and clinically credible decision-making across the Greater Manchester system. This may arise from prolonged workload pressure, recruitment constraints, ongoing reform and limited resilience within a lean portfolio model. If this risk materialises, the ICB's ability to lead quality, safety, transformation and clinical strategy delivery could be weakened, with consequential impact on system performance, service improvement and outcomes for the GM population. **Cause** The sustainability and resilience of the Clinical and Care Professional Leadership (CCPL) workforce is challenged by sustained system pressure and structural constraints. Demand on CCPL roles has remained high since the COVID 19 pandemic and has increased through NHS reform, with more activity becoming reactive, time critical and assurance focused rather than planned, developmental or improvement led. These pressures are compounded by financial constraint, recruitment restrictions and continuing change in roles, responsibilities and organisational arrangements. The Greater Manchester system is complex and the ICB has established a lean clinical portfolio model to provide leadership across statutory, commissioning and transformation responsibilities. This model now needs to be sustained and tested for resilience, capacity and capability through 2026/27. **Impact** This is an ICB leadership capacity risk with direct implications for how effectively NHS Greater Manchester can operate as a strategic commissioner and system leader. If CCPL capacity or resilience is reduced, the ICB may be less able to provide consistent clinical and professional oversight, shape commissioning decisions, support delivery of the clinical strategy and drive improvement across organisational boundaries. This would increase the risk of slower transformation, weaker assurance around quality and safety, reduced clinical credibility in decision-making and less impact on outcomes across the GM system. **Morale, resilience and culture**	4	5	20	↔	6-12 months	Preventative •Established clinical portfolio structure with defined leadership responsibilities and clearer accountability across CCPL roles. •CCPL leadership aligned to statutory functions and core quality, safety and safeguarding responsibilities. •Clinical and care professional leadership embedded within core commissioning and strategic decision-making processes. •Board-level nursing leadership in place to support strategic clinical and professional input. •Dedicated CCPL roles established within the commissioning portfolio to support delivery of ICB priorities. •GM CCPL Framework in place to support leadership development, mentoring and succession planning. •CCPL embedded within transformation, redesign and improvement programmes to maintain clinical credibility and leadership contribution. •Matrix working arrangements in place across priority programmes to distribute leadership workload and reduce reliance on a small number of senior roles. •Regular CCPL engagement and development activity supports shared purpose, peer support and leadership resilience. •Relevant GM workforce and retention strategies support broader sustainability of the clinical leadership pipeline. •Organisational development support in place to strengthen team effectiveness and ways of working across the clinical portfolio.	Further work is required to define sustainable clinical leadership capacity and accountabilities within the developing GM operating model, ensuring effective alignment between place, provider and system leadership arrangements.	4	5	20	1. Strengthen CCPL sustainability, development and succession (Ongoing) Implement the GM CCPL Framework and Clinical Leadership Model to strengthen role clarity, leadership development, succession planning and resilience across the clinical portfolio. Ensure alignment with the evolving ICB operating model and confirm the leadership capacity required to sustain delivery of statutory, commissioning and transformation responsibilities. 2. Improve role sustainability and distribution of leadership workload (Ongoing) Review and strengthen matrix working arrangements across strategic commissioning and priority programmes to distribute workload more effectively, reduce duplication and improve resilience within senior CCPL roles. 3. Support retention, engagement and future leadership pipeline (Ongoing) Maintain a focused programme of CCPL engagement, development and peer support, aligned to relevant GM workforce strategies, to support retention, leadership sustainability and future pipeline development. 4. Maintain oversight of CCPL capacity and reform impacts (Ongoing) Maintain regular review of CCPL capacity and resilience through clinical portfolio oversight and reporting to CEG and SCC, with escalation of emerging risks where workforce, reform or delivery pressures exceed available leadership capacity.	The Clinical Strategy is in place and provides clearer articulation of the role and contribution of clinical leadership, supporting improved alignment with system priorities during a period of reform and pressure. Implementation of the clinical portfolio structure is progressing and is improving organisational clarity and routes for CCPL involvement across strategic commissioning and programmes. Targeted engagement and co-design activity has informed development of the Clinical Leadership Model, with a focus on professional development, role clarity, succession planning and peer support. This has strengthened understanding of how CCPL roles can be better supported and sustained. Overall, progress has been made in strengthening leadership development, improving role clarity and maintaining focus on retention and future pipeline. Further engagement is planned to continue monitoring workload, reform impact and sustainability as the operating model evolves. 5. Review and refresh the risk description, controls and mitigations in line with NHS reform, Place Partnership governance arrangements and the developing clinical governance model, with a view to establishing clear milestones for risk reduction and closure.	Clinical Strategy implementation has commenced and the Clinical Leadership Model continues to be developed through extensive engagement and co-design activity. Clinical Portfolio structures and leadership roles have been reviewed to improve sustainability, resilience and alignment with strategic commissioning priorities. Recruitment activity, leadership development initiatives and the emerging Clinical Governance Framework are strengthening role clarity, succession planning and clinical leadership contribution to governance and decision-making. Ongoing oversight continues through CEG and SCC.	Kate Provan, Associate Director of Clinical Effectiveness and Improvement	Set out in narrative in relation to actions	Executive ownership sits with the Chief Clinical Officer, supported by the Clinical Portfolio Team. Formal oversight is provided through the Strategic Commissioning Committee and the Clinical Effectiveness and Governance Committee, with risks escalated through established ICB governance routes. Routine review through clinical portfolio and cross-directorate governance supports ongoing monitoring of capacity, resilience and delivery risk.	Assurance is not yet sufficient to demonstrate consistently that CCPL capacity and resilience risks are being identified early, managed proactively and linked to their impact on delivery across the ICB and wider GM system.	3	5	15	GM	GM	Oct-26	31/03/2027	Open	
CCPL09B To rename CEG2 and to continue to report into Clinical Effectiveness and Governance	NHS GM CEG	Quality and Safety	3. Both	Jan-25	**Manisha Kumar, Chief Clinical Officer**	**Clinical leadership assurance, governance and statutory compliance (including Place assurance)** **Risk** There is a risk that clinical advice, challenge and assurance are not consistently embedded in ICB decision making, commissioning and transformation across Greater Manchester during transition to the Model ICB and ongoing financial and organisational change. As place based arrangements evolve and legacy advisory routes fall away, assurance may vary across places and programmes, reducing clarity about where advice should be obtained, how it should be applied, and when concerns should be escalated. This could lead to poorly evidenced clinical input to key decisions, increasing the risk of sub optimal prioritisation, weaker quality and safety oversight, and inconsistent compliance with national expectations and the statutory duty to obtain appropriate clinical advice. If unmitigated, this may undermine confidence in system governance and the robustness of decisions taken at pace. This is a structural assurance risk that is likely to persist through the reform period and requires ongoing management. **Cause** This risk arises from the scale and pace of NHS reform, transition to the Model ICB, and sustained financial pressures requiring rapid system level prioritisation and decision making. Together, these changes increase the risk that clinical and care professional advice is not consistently embedded in commissioning, transformation and financial decisions, and that assurance routes become fragmented as legacy arrangements change. The size and complexity of the Greater Manchester system, including multiple organisational and place based layers, can create variation, duplication and lack of clarity in governance routes for clinical advice, challenge and assurance. This increases the risk that clinical advice is not consistently sought, applied, escalated or evidenced across places and programmes.. **Impact** This risk primarily impacts the quality, safety, governance and assurance of system decision making and delivery of strategic objectives. **Clinical leadership assurance and decision making** If clinical leadership is not consistently embedded in decision making, commissioning, transformation and prioritisation decisions may not be fully informed by appropriate clinical advice, challenge or insight.	4	5	20	↔	6-12 months	Preventative •Established governance arrangements supporting clinical leadership input into decision making, including the Clinical Pathway, Audit and Standards Group and the Clinical Effectiveness and Governance Committee (CEG), reporting through to the Strategic Commissioning Committee(SCC). •Clinical and care professional leadership embedded as a core partner in system transformation, redesign and commissioning activity, supporting clinically informed prioritisation and delivery. •Development of the GM Clinical Governance Framework, in collaboration with the Royal College of Physicians Edinburgh, to strengthen clarity, consistency and expectations for clinical leadership, challenge and assurance across the system. •Ongoing work to align CCPL representation and responsibilities within evolving governance and programme structures, including the development of the Clinical Leadership Model and Clinical Portfolio arrangements. •Continued engagement of clinical leaders through structured forums and priority function clinical leadership groups to support consistent clinical input and challenge across system priorities. Detective •System level oversight of clinical leadership assurance through the NHS GM Clinical Effectiveness and Governance Committee (CEG) and the SCC, with regular reporting on quality, safety and clinical risks.	The principal gaps relate to ensuring consistent clinical governance arrangements across place and provider partnerships, clarifying escalation and assurance routes between place, provider and GM-level structures, and embedding a common approach to clinical governance oversight as organisational reform progresses.	4	5	20	1. Strengthen clinical leadership assurance within system decision-making (Ongoing) Deliver the Clinical Strategy with a clear focus on embedding effective clinical and care professional leadership in commissioning, transformation and prioritisation, ensuring clinical input and challenge are consistently applied to high impact decisions affecting quality, safety and outcomes. Implement the GM Clinical Governance Framework, in collaboration with the Royal College of Physicians Edinburgh, to strengthen clarity of assurance routes, role expectations and accountability for clinical leadership across the system. 2. Strengthen assurance routes within the Model ICB and Clinical Portfolio structures (Ongoing) Align CCPL roles, forums and responsibilities to the new Clinical Portfolio and Model ICB arrangements, ensuring clear routes for how clinical advice is obtained, considered, escalated and evidenced within programme governance, place interfaces and key decision making structures. Strengthen matrix working and clinical leadership forums in priority areas to support timely access to clinical advice, challenge and escalation where required. 3. Align and strengthen system-wide clinical risk and assurance arrangements (Ongoing) Refresh and align the clinical risk management approach in line with the National Quality Board (2024) principles and the corporate risk review, ensuring consistency in how clinical leadership assurance risks are identified, mitigated and reported across the system. Improve alignment of clinical leadership assurance risks across organisational risk registers to support coordinated system-level oversight and mitigations.	Progress has been made in strengthening clinical leadership assurance within system decision making as NHS Greater Manchester transitions through reform and the Model ICB. The Clinical Strategy now provides clearer expectations for the role of clinical leadership in commissioning, transformation and prioritisation, supporting more consistent input to high impact decisions. Work to align Clinical Portfolio structures and governance arrangements is also improving clarity about where and how clinical leadership is engaged. Insights from the Clinical Leadership and Strategy Co Design Workshop and subsequent engagement continue to inform development of the Clinical Leadership Model, with a focus on strengthening routes for clinical challenge, escalation and assurance within system governance. This is supporting clearer alignment between clinical leadership roles, programme governance and statutory requirements. The clinical risk management approach has been refreshed in line with National Quality Board (2024) principles and reviewed through CEG and QPC, improving visibility of clinical leadership assurance risks and consistency of mitigations across the system. Overall, progress has been made in embedding stronger clinical leadership assurance within system governance and decision making; however, the risk rating remains unchanged due to the ongoing pace of NHS reform, financial pressures and the scale of system transformation still underway. 5. Review and refresh the risk description, controls and mitigations in line with NHS reform, Place Partnership governance arrangements and the developing clinical governance model, with a view to establishing clear milestones	Implementation of the Clinical Strategy, development of the Clinical Leadership Model and ongoing development of the GM Clinical Governance Framework have strengthened the visibility and contribution of clinical leadership within governance and decision-making processes. Alignment of Clinical Portfolio structures, governance arrangements and clinical risk management processes has improved clarity of assurance routes and escalation mechanisms. Further work is required to achieve consistent system-wide assurance as Model ICB arrangements continue to	Kate Provan, Associate Director of Clinical Effectiveness and Improvement	Set out in narrative in relation to actions	Overall ownership of this risk sits with the Chief Clinical Officer Senior Leadership Team providing senior clinical oversight of clinical leadership assurance and statutory decision making across the system. Assurance is provided through established governance and clinical oversight arrangements, including review at Clinical Portfolio risk meetings, the CCPL work programme and priority function clinical leadership groups. These forums provide structured routes for clinical input, challenge and escalation within commissioning, transformation and financial decision making. Formal assurance is maintained through regular reporting to the Strategic Commissioning Committee via the CCO report, with system level scrutiny provided by the NHS GM Clinical Effectiveness and Governance Committee (CEG). Development of the GM Clinical Governance Framework, supported by the Royal College of Physicians Edinburgh through writing groups and workshops, provides additional assurance on the clarity, consistency and robustness of clinical leadership roles, responsibilities and assurance routes across the system. Emerging assurance is provided through Place Partnership governance arrangements, with oversight through regular Place Clinical Director engagement and developing interfaces between place-based governance, provider governance and	There is not yet full, consistent system level assurance that clinical and care professional advice is obtained, applied, escalated and evidenced across all commissioning, transformation and financial decision making routes, particularly as governance arrangements and place based interfaces continue to evolve through NHS reform and transition to the Model ICB. This limits confidence that clinical challenge and statutory requirements are being met consistently across the system and that decisions taken at pace remain robust and appropriately assured.	3	5	15	Clinical	GM	Oct-26	31/03/2027	Open	
CCPL17 Rename QOM2 and and assign to Quality Oversight Meeting from Nov 2026 onwards	NHS reform	Quality and Safety	3. Both	07/05/2025	**Manisha Kumar, Chief Clinical Officer**	**Risk -** There is a risk that the level of quality oversight and assurance of maternity and neonatal services will reduce in NHS GM which may result in a reduction in the quality and clinical safety of care and poorer outcomes for the people of Greater Manchester.. **Impact -** Provider and system level Maternity quality improvement will be impacted due to reduction in financial flows and WF capacity. Clinical quality will deteriariate, national 3 year maternity plan actions will not be acheived, potential for maternity safety outcomes to decline. **Cause -** As a result of the NHS Reform programme and financial efficencies nationally and in GM, the capacity of staff may be impacted along with financial support to implement QI work at system and provider level. This includes E&E, WF, MCOC. Changes in role and function of ICB / region / providers may result in temporary reduction in quality oversight and assurance of maternity services in GM	4	4	16	↔	0-3 months	Bi monthly monitoring of quality and safety outcomes in maternity shared with system. Realigning exisiting resources (WF and financial) around safety priorities. Regular liasion with GM finance collegues.	Future hosting arrangements and long-term capacity for the GM LMNS remain unconfirmed. Until a sustainable operating model is agreed, there is limited assurance that sufficient programme management, quality improvement, clinical expertise and commissioning capacity will be maintained to deliver increasing national maternity requirements and sustain system-wide quality oversight during NHS Reform	4	4	16	Despite robust oversight arrangements currently being maintained, maternity and neonatal services remain a nationally recognised high-risk patient safety area. Continued uncertainty regarding future capacity, expertise and hosting arrangements for the GM LMNS, coupled with increasing national maternity requirements, means there remains a significant risk to the sustainability of quality oversight and improvement activity during the NHS Reform transition.	Continue regular information flows on risk and challenges across the system and with Providers. Align resource against maternity safety priorities. Monthly monitoring of maternity outcomes via GM Maternity Dashboard, overseen by the GM Maternity & Neonatal System Group. Regular discussions with GM Chief Officers to ensure maternity quality and safety considered in GM Reform, governance and capacity. Linked conversations with NHSE regional team to outline future	A proposed GM LMNS Target Operating and Hosting Model has been developed and shared with Chief Officers. Quality and safety oversight continues through the GM Maternity Dashboard, bi-monthly monitoring processes and the GM Maternity & Neonatal System Group. Planning is also	Alison McGovern	Set out in narrative in relation to actions	Bi-monthly monitoring of provider and system maternity quality and safety indicators and monthly oversight of maternity outcomes through the Greater Manchester Maternity Dashboard. Oversight provided through the Greater Manchester Maternity & Neonatal System Group, supported by regular reporting and escalation through established governance arrangements. Ongoing financial assurance arrangements remain in place alongside regular engagement with NHS GM executive leadership and NHS England regional colleagues regarding quality, safety and	Assurance is limited until future governance, hosting and accountability arrangements for the GM LMNS are confirmed. Uncertainty remains regarding the system's ability to deliver forthcoming national maternity requirements, including	3	3	9	Clinical	GM	Sep-26	Mar-27	Open	
QOM3	NHS GM ICB provider quality and performance oversight, informed by Care Quality Commission regulatory activity	Quality and Safety	3. Both	29/09/2026	**Manisha Kumar Chief Clinical Officer**	There is a risk of patient harm and poor outcomes due to delayed or substandard care arising from the scale of quality, governance, operational and digital improvement required at Northern Care Alliance NHS Foundation Trust. **Causes** - Cumulative weaknesses in culture, governance, incident and complaints management, operational performance and digital systems. - Active quality concerns across several clinical services, prolonged waits and reliance on paper prescribing following the loss of EPMA. **Impact and consequences** - Avoidable harm, delayed care and poorer patient outcomes and experience. - Continued service and system pressures, including medicines-safety risks. - Failure to meet regulatory requirements, with increased financial, governance and reputational consequences.	5	5	25	NEW	6-12 month	**Preventative controls** - NHS England-led System Improvement Board and a developing single improvement plan. - NHS GM ICB quality, contractual, clinical governance and performance oversight. - Standardised paper-prescribing arrangements following the loss of EPMA. **Detective controls** - Baseline assurance and monitoring of quality, safety, performance and business-continuity risks. - CQC regulatory oversight and System Improvement Board review of progress. - MIAA review of the ICB's response to provider clinical risk. **Corrective controls** - Coordinated improvement action, support and challenge through the System Improvement Board. - Collective agreement for management of Quality Review Meetings with CQC, NHSE, ICB and Specialised Commissioning. - Development of interim and longer-term digital solutions. - Escalation through established NHS GM ICB	1. The baseline assurance assessment and single improvement plan are not yet finalised. 2. Cross-organisational responsibilities and accountabilities require further agreement. 3. Measurable milestones, patient-outcome indicators and escalation triggers require further definition. 4. Interim and longer-term digital solutions, including arrangements following the loss of EPMA, remain unresolved. 5. The timescale for implementation of a replacement electronic patient record means that material digital fragility may persist for several years. 6. The cumulative and interdependent nature of the concerns may limit the effectiveness of individual service-level controls.	4	5	20	This is a new and material corporate risk. The consequence is proposed as catastrophic because the concerns span multiple services and organisational systems and create the potential for significant patient harm, delayed access and poor outcomes across a large patient population. The likelihood is proposed as likely because regulatory action has already been taken, several quality and safety concerns are active, access pressures remain, and the loss of EPMA has created an ongoing medicines-safety exposure. Controls and strengthened oversight are in place, but assurance is not yet sufficient to demonstrate that mitigations are consistently effective. Improvement is embedded or the risk is reducing. The final scores should be confirmed using the NHS GM corporate risk-scoring matrix and evidence from quality, performance, digital and provider-oversight leads.	**Action 1**: Establish a consolidated ICB assurance baseline- Complete an ICB assessment of the current quality, safety, performance, contractual and digital risks, including the strength of existing controls and any gaps requiring escalation. **Action 2**: Agree the ICB assurance and oversight approach- Define how NHS GM ICB will discharge its statutory quality and commissioning responsibilities within the NHS England-led System Improvement Board, including reporting, information-sharing and escalation routes. **Action 3**: Strengthen monitoring and escalation- Agree a concise ICB assurance dashboard with measurable quality, safety, access, patient-outcome and business-continuity indicators, supported by clear escalation and risk re-scoring triggers. **Action 4**: Maintain oversight of digital and medicines-safety risks- Seek and review assurance from NCA on the safety of paper prescribing, the residual EPMA risk and interim and longer-term digital mitigations, escalating concerns through ICB governance where required. **Action 5**: Coordinate ICB oversight of service-specific concerns- Bring together ICB quality, performance, contracting and clinical intelligence on spinal, gynaecology, renal haemodialysis, neonatal intensive care, haematology and Freedom to Speak Up concerns to support coordinated challenge and escalation. **Action 6**: Complete and implement learning from the MIAA		Claire Smith Associate Director of Nursing & Quality	Set out in narrative in relation to actions	**Internal assurances** - NHS GM ICB quality, contractual, clinical governance and performance oversight. - Provider Oversight Meeting handover prepared to support transition to the System Improvement Board. - Business Continuity Assurance Meeting oversight of digital and associated patient-safety risks. - Reporting and escalation through NHS GM ICB governance, including the Strategic Commissioning Committee. - MIAA review commissioned to assess and strengthen the ICB response to provider clinical risk. **External and independent assurances** - CQC regulatory oversight through the Section 29A Warning Notice. - NHS England-led System Improvement Board, held monthly (first held on 3 September 2026). - Engagement with NHS England regional colleagues and the CQC on future assurance arrangements. **Positive assurance received** - A formal system oversight mechanism has been established through the System Improvement	1. Baseline assurance has not yet been finalised. 2. The single improvement plan is not yet sufficiently mature to provide assurance on scope, ownership, milestones, impact or sustainability. 3. There is incomplete evidence that current mitigations are operating consistently and reducing patient risk. 4. Cross-organisational responsibilities and accountabilities have not yet been fully agreed. 5. Interim and longer-term digital solutions	2	5	10		GM	Oct-26	31/03/2027	Open	

QOM4	Clinical Effectiveness and Governance Committee paper: GM LMNS Perinatal Mental Health Programme – Strategic System Response to Maternal Mental Health Risk	Quality and Safety	3. Both	01/10/2026	**Manisha Kumar Chief Clinical Officer (proposed)**	There is a risk of serious harm or maternal death, including suicide, among women experiencing significant perinatal mental health deterioration following discharge from maternity services, specifically where there is significant safeguarding involvement and/or actual or anticipated parent–infant separation, because current service thresholds and pathway arrangements may prevent access to specialist perinatal mental health support and coordinated care across the end-to-end mental health pathway. Causes - A known gap in current specialist mental health service eligibility for some women experiencing significant statutory safeguarding intervention, including actual or anticipated parent–infant separation. - Risk persists beyond discharge from maternity services, particularly between 42 days and one year after birth, when responsibility transfers across maternity, mental health, safeguarding, primary care, health visiting, community and social care services. - Greater Manchester does not yet have a comprehensive system-wide understanding of Significant Perinatal Mental Health Events, population need, pathway gaps or variation by ethnicity, deprivation and locality. - Multiple and overlapping vulnerabilities, including domestic abuse, substance misuse, trauma, social disadvantage and involvement with children's social care, may increase the risk of deterioration and crisis. -There is currently no consistently embedded whole-system model for identifying, assessing and supporting women affected by actual or anticipated parent-infant separation as a result of safeguarding, resulting in variation in practice, fragmented pathways and uncertainty regarding lead professional and organisational responsibilities Impact and consequences - Serious self-harm, attempted suicide, maternal suicide or maternal death. - Adverse outcomes for infants, the parent–infant relationship and wider families. - Inequitable access, experience and outcomes for women with complex safeguarding and social vulnerabilities. - Failure to provide a coordinated system response, with gaps in accountability, assurance and strategic	**5**	**5**	**25**	NEW	Current / ongoing	Preventative controls - Established GM maternity pathways for early identification, assessment and management of perinatal mental health risk during pregnancy and the early postnatal period. - Referral to universal - specialist Perinatal and Parent Infant Mental Health services for women who meet existing criteria, with multidisciplinary care planning and access to specialist psychiatric support where clinically indicated. - GM LMNS Perinatal Mental Health Programme established with a phased approach covering population need, pathway review and strategic commissioning. - Collaborative programme leadership involving GM LMNS, the GM Perinatal and Parent Infant Mental Health Team, GM Safeguarding, Data, Intelligence and Informatics and wider system partners. Detective controls - Multidisciplinary review of individual maternal deaths and learning from statutory safeguarding reviews. - Phase 1 analysis of maternal mortality and Significant Perinatal Mental Health Events, including ethnicity, deprivation and locality. - Planned triangulation of maternal mortality findings with the wider Significant Perinatal Mental Health Events cohort. Corrective controls - Phase 2 review and mapping of the end-to-end	1. Women experiencing significant safeguarding intervention, including actual or anticipated parent–infant separation, do not routinely meet existing specialist perinatal mental health referral criteria. 2. There is no comprehensive system-wide understanding of the scale and nature of Significant Perinatal Mental Health Events across Greater Manchester. 3. The end-to-end pathway from 42 days to one year following birth has not yet been fully mapped or assessed against population need. 4. There is currently no consistently embedded whole-system model for identifying, assessing and supporting women affected by actual or anticipated parent-infant separation as a result of safeguarding, resulting in variation in practice, fragmented pathways and uncertainty regarding lead professional and organisational responsibilities 5. Transfers of responsibility and accountability across maternity, mental health, safeguarding, primary care, health visiting, community and social care require further assessment. 6. The consistency and effectiveness of	**4**	**5**	**20**	This is a proposed new corporate risk. The impact is proposed as catastrophic because the identified pathway gap could contribute to serious self-harm, maternal suicide or maternal death, with consequences for infants and families. The likelihood is proposed as likely because local maternal mortality intelligence identifies continuing deaths by suicide after discharge from maternity services and national and local learning identifies recurring safeguarding themes. Existing pathways and the newly established programme provide controls, but the full scale of need, the effectiveness of the end-to-end mental health pathway and the adequacy of interim mitigation have not yet been established. The scores should be confirmed using the NHS GM corporate risk-scoring matrix and reviewed as Phase 1 intelligence and the pathway review become available.	Action 1: Complete Phase 1 population-needs analysis – Analyse maternal mortality and Significant Perinatal Mental Health Events to establish scale, risk factors and variation by ethnicity, deprivation and locality. Action 2: Complete the end-to-end MH pathway review – Map provision, transitions, responsibilities and multi-agency arrangements from pregnancy through to one year after birth, with particular focus on the period after discharge from maternity services. Action 3: Define and implement interim mitigation – Agree a proportionate interim response for women experiencing significant safeguarding intervention, including actual or anticipated parent–infant separation, while longer-term pathway and commissioning work is completed. Action 4: Strengthen system oversight and escalation – Agree governance, reporting, accountability, information-sharing and escalation arrangements for the residual risk. Action 5: Develop an assurance and outcomes framework – Establish measurable indicators covering Significant Perinatal Mental Health Events, access, transitions, serious harm, maternal outcomes, infant and family outcomes and inequalities. Action 6: Develop strategic commissioning recommendations – Use findings from Phases 1 and 2 to produce evidence-based proposals for pathway redesign, service development and commissioning.	Phase 1 data analysis has commenced. Further progress and completion dates should be updated through the programme governance arrangements.	Sarah Marshall Assistant Director of Mental Health Strategic Commissioning Sarah Owen Associate Director of Maternity with relevant GM programme and system leads	To be confirmed through the Perinatal Mental Health Programme plan	Internal assurances - GM LMNS has established a formal Perinatal Mental Health Programme on behalf of NHS Greater Manchester. - Phase 1 data analysis has commenced with the GM Data, Intelligence and Informatics Team. - Existing maternity and specialist perinatal mental health pathways support identification, referral, multidisciplinary care planning and specialist psychiatric input for women who meet current criteria. - Individual maternal deaths are subject to multidisciplinary review. - A GM-wide Perinatal Mortality Deep Dive is already underway via the NHS GM Mental Health Clinical Director & leads, providing additional intelligence on maternal deaths, contributory factors and opportunities for system improvement. - Programme oversight and escalation are being progressed through NHS Greater Manchester governance, including the Clinical Effectiveness and Governance Committee. - Clinical, safeguarding and service-user engagement has commenced through relevant system partners and the Maternity and Neonatal Voice Partnership. External and independent assurances - National learning from MBRRACE-UK informs understanding of late maternal death and maternal	1. The scale, distribution and characteristics of Significant Perinatal Mental Health Events across Greater Manchester are not yet fully established. 2. There is not yet assurance that current pathways consistently identify and support women at highest risk after discharge from maternity services. 3. Existing specialist eligibility does not routinely include all women experiencing significant statutory safeguarding intervention or actual or anticipated parent–infant separation. 4. The effectiveness of transfers, information-sharing and accountability across agencies has not yet	**2**	**5**	**10**	Maternity, Mental Health, Safeguarding and Strategic Commissioning	Greater Manchester	Oct-26	31/03/2027	Open

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NHS Greater Manchester Strategic Commissioning Committee

Report from Chief Commissioning Officer

November 2026

NHS
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Report from:	**Katherine Sheerin, Chief Commissioning Officer**
Date of Meeting:	04 November 2026
Authors	**Caroline Bradley** – Director of Primary Care and Community Healthcare Services **Emma Storer** - Senior Project Manager Children & SEND **Gill Baker –** Director of Healthcare Commissioning
Executive Summary	This paper sets out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate.

ALERT

Healthcare Commissioning

No alerts this month.

Children, Young People and Maternity

No alerts this month.

Primary Care Commissioning

No alerts this month. Previous SCC reports have provided an update on GP Collective Action and the introduction of a series of monthly actions by GPC England. No new actions have been introduced by GPC England for September or October 2026.

ADVISE

Healthcare Commissioning

Establishment of a NW Individual Funding Request Service (hosted by NHS Greater Manchester)

The three NW ICBs (NHS Cheshire & Mersey, NHS Greater Manchester and NHS Lancashire and South Cumbria) have collaborated to develop a single, Integrated Clinical Policy and Individual Funding Request Service, hosted by NHS Greater Manchester.

The model is intended to reduce variation, support fair and evidence-based decisions, improve efficiency and align clinical policy development across Greater Manchester, Cheshire and Merseyside, and Lancashire and South Cumbria.

The proposed service includes Individual Funding Requests, non-Individual Funding Requests, relevant mental health cases and clinical policy development.

This will benefit the populations of three ICBs by:

- Ensuring more consistent access to treatments through a shared North West approach to clinical policy and individual funding request decision-making.
- Fairer, more transparent and clinically evidence-based decisions for exceptional funding requests.
- Reduced variation in provision and fewer cross-border differences between ICB areas.
- Improved use of resources through shared processes, reduced duplication, policy harmonisation and economies of scale.
- Better identification of policy gaps and unmet need, supporting future commissioning decisions and demand management.

All three ICBs formally approved the proposal at their Chief Officer / Executive meetings in August and September which has now triggered the launch of a formal consultation for those staff delivering the service for NHS Cheshire and Merseyside and Lancashire and South Cumbria, in Midlands and Lancashire Commissioning Support Unit (MLCSU). Following consultation, the staff will transfer to NHS GM on 1 November. Enabling work continues involving HR, Organisational Development, Information Governance, and IT to ensure staff transfer safely. Post November, work will continue to implement the single, NW Integrated Clinical Policy and Individual Funding Request Service.

Children, Young People and Maternity

Area SEND inspection – Wigan Local Area Partnership has recently undergone an Area SEND inspection. Jointly carried out by Ofsted and the CQC, the inspection assesses how effectively the local area partnership supports children and young people with SEND and, where appropriate, identifies areas for improvement. The inspection concluded on 23rd October, with the outcome to be confirmed when the full report is published.

Primary Care Commissioning

The initial phase of a multi-year approach to the Primary Care Service Development Fund (SDF) has been agreed. Phase 1 allocates an initial £1.169m in 2026/27.

Approval of the funding, and associated programmes of work, will deliver significant benefits for the people and communities of Greater Manchester by strengthening and increasing the resilience of primary care services, helping reduce unwarranted variation,

improving patient access to care & experience and enabling Primary Care neighbourhood & system leadership.

The key benefits include:

- Improved and more timely access across general practice, pharmacy, dentistry and optometry, including same-day urgent care.
- More consistent, high-quality and safe care through targeted improvement, peer support and assistance for identified practices.
- Stronger neighbourhood-based care tailored to local needs and delivered closer to home.
- A more resilient primary care workforce able to meet growing demand.

Phase 2 of the Primary Care SDF focusing on delivery of the Primary Care Blueprint and neighbourhood leadership / development is currently being finalised to ensure plans for 2026/27 strengthen and build on current arrangements with the ability to evolve the model further in 2027/28.

ASSURE

Healthcare Commissioning

Greater Manchester Tier 3 Community Dermatology Service

NHS Greater Manchester has formally launched the procurement of the Provision of a Tier 3 Community Dermatology Service in Greater Manchester. This follows the decision to abandon the previous procurement following a challenge to the process.

The GM service will deliver a community dermatology service across all localities within Greater Manchester for patients registered with a Greater Manchester GP. Tenders are invited from interested parties to provide a consistent service across GM, for a range of appropriate conditions which can be assessed, investigated and treated in the community.

This will address the current variation that exists across GM, providing a sustainable service for patients. This service will also reduce demand for secondary care providers. The deadline for the tenders has been extended to 30 October to allow bidders to consider the responses to a number of clarification questions. Following this, there will be a period of evaluation and recommendation for a successful bidder. The aim is for a new service to be mobilised from April 2027.

Children, Young People and Maternity

Oldham SEND Stocktake Meeting: Review of strategic plan and priority action plan

A SEND stocktake meeting was held on 30 September 2026 to review the progress made against Oldham's Priority Action Plan (PAP) and your Strategic Plan following the

Ofsted/CQC monitoring inspection in February 2026, and the lifting of the Improvement Notice in April 2026.

The feedback was received on 14th October and confirmed that the evidence shared before and during the stocktake provided assurance that Oldham has continued to make progress following the monitoring inspection and is increasingly focused on embedding improvement through business-as-usual arrangements.

Inspectors stated that they were particularly encouraged by the partnership's openness about continuing risks and its determination not to accept the status quo. They highlighted that discussion showed growing maturity in the way risks are identified, escalated and mitigated, alongside a stronger focus on lived experience, impact and outcomes. This provides a credible platform from which to sustain the progress made and deliver longer-term reform for children and young people (CYP) with SEND.

Clear progress was noted across the two Areas for Priority Action with some further areas for improvement highlighted and next steps set out.

Given the above, the Inspectors recommended adjusting the current monitoring approach to reflect Oldham's progress and current circumstances, with future assurance provided through routine regional oversight rather than the existing formal monitoring schedule.

Primary Care Commissioning

Primary Care Commissioning Group took place on 13 October 2026 with the agenda covering the following areas:

Primary Care Winter Planning 2026/27

An update on primary care winter planning for 2026/27 was provided, this included a high level overview of locality plans and areas identified for investment. Evidence shows that increased primary care capacity to provide timely, responsive and proactive care over winter helps meet additional demand to reduce pressure on urgent care services and avoid unplanned admissions. Plans include additional GP winter surge capacity, a focus on acute respiratory infections (ARI) and CUES across Greater Manchester. Further clarity from a small number of localities is being sought to understand specific plans. Discussions are also on-going with Primary Eyecare Services (PES) to understand further plans to support winter pressures.

BeCCoR – Elective 2026/27: Revised Specification

Proposed revisions to the 2026/27 Elective specification for BeCCoR were approved. The changes respond to General Practice feedback, emerging performance data and the continued development of SPoA pathways across Greater Manchester. The revised specification retains the focus on Advice First and the 10% A&G improvement requirement, removes the individual practice-level referral-reduction requirement, and strengthens the QI and engagement requirement.

A series of next steps were agreed to support implementation of the changes. These include:

- The revised specification will be finalised and issued to GP practices, together with clear communication summarising what has changed and why.
- A GM-wide BeCCoR Elective webinar will be held for practices to take GP practices through the revised requirements, QI/engagement expectations, A&G requirement and arrangements for exceptionality.
- Supporting BeCCoR guidance and FAQs will be updated to reflect the approved specification.
- Practices will continue QI, Advice First, LIN and SPoA engagement activity through the remainder of 2026/27. Achievement will be assessed by 31 March 2027, with sample-based PPV from April 2027.

Little Lever

PCCG considered the options presented in respect of future management of the registered list of patients at Little Lever Health Centre 2 (LLHC2). The options presented have been developed in line with the NHS England Policy Guidance Manual (PGM). Following consideration of the 2 options – 1. Managed list dispersal or 2. Procurement, PCCG supported the option to undertake a managed dispersal of the list. This was agreed based on the small practice list size and alternative provision available through GP practices within a defined radius. The managed list dispersal will be accompanied by a 6 month extension to the current contract arrangements to enable engagement and due diligence.

The LMC has been engaged in the process and the current provider will be communicated with to outline the PCCG decision and next steps.

Community Pharmacy Prescribing Development Programme

An overview was provided on the nationally commissioned Community Pharmacy Prescribing Services which are due to launch in October/November 2026, and an introduction to the NHS England pilot “Prescribing Development Programme (PDP)” which will be locally commissioned.

In addition, the overview also described the proposed approach to local governance and assurance of Community Pharmacy Prescribing Services, and explained why this approach is deemed necessary, in contrast to other nationally commissioned community pharmacy services.

PCCG supported the recommendation to approve the proposed governance arrangements with further detail to be presented to a future PCCG.

ACHIEVEMENTS

Healthcare Commissioning

Two new service specifications have recently progressed through the Commissioning Delivery Group (CDG) and are currently undergoing final review and sign-off by the Clinical Effectiveness Group (CEG).

The Adult Community Musculoskeletal (MSK) Specification, developed by the national Getting It Right First Time (GIRFT) Programme, which has gone through a GM review, aims to standardise the delivery of MSK care across community settings. The Greater Manchester District Nursing Specification seeks to establish a consistent core district nursing offer across GM.

Both specifications are designed to improve service quality, strengthen core standards, and reduce unwarranted variation in care, ensuring GM residents receive more equitable and consistent services regardless of where they access care.

Children, Young People and Maternity

SEND Reforms – All ten Greater Manchester local area SEND partnerships have received government approval for their Local SEND Reform Plans, which outline their vision, strategy and roadmap for implementation of the SEND reforms. The approval confirms that the plans meet the required threshold and provide a strong basis for delivery. Each area is meeting with the DfE to discuss feedback, with quarterly reviews planned to maintain a close focus on progress.

Primary Care Commissioning

No updates this month.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

Healthcare Commissioning

The Board Assurance Framework (BAF) – Strategic Commissioning Committee Risk

Appended to this report as Appendix 1, is the updated System Transformation Risk, which covers the risk owned by the Strategic Commissioning Committee (SCC). From an action and mitigation perspective, five of the six actions are on track, with one delayed. Members of the SCC are welcome to follow up with the necessary Programme and Directorate Leads, should they have any specific questions.

Children, Young People and Maternity

No updates this month.

Primary Care Commissioning

No updates this month.

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Appendix 1 – Revised BAF Update

Strategic Objective	System transformation.		
Chief Officer / Committee	**Risk owner:** Chief Commissioning Officer **Primary committee:** Strategic Commissioning Committee		
Risk Appetite Level	**Cautious to Open**	Risk Tolerance Range 5 - 15	**5-15**

Rationale for Risk Score and Progress made in the quarter
Proposed current score: 12 (likelihood 3 x impact 4), within tolerance. The risk has been reduced slightly due to progress / developments in a number of transformation initiatives however still remains a moderate risk as ongoing transformation requires simultaneous change to funding, contracting, workforce, clinical models, digital capability and provider behaviours across GM. Principal drivers are: sustained demand and financial pressure; strategic commissioning capacity and capability; variable maturity across places, neighbourhoods and providers; limited headroom to invest ahead of releasing acute capacity; workforce constraints; incomplete impact modelling and benefits realisation; fragmented data/digital adoption; approach to consistent implementation discipline; and resistance to service redesign. Progress: the five-year Strategic Commissioning Plan sets the three shifts and outcomes; a performance scorecard is intended for Board and Strategic Commissioning Committee reporting; place partnership arrangements and provider collaboration are identified as delivery mechanisms; and a system method for modelling the Left Shift is planned during 2026/27. Risk reduction depends on translating the strategy into a prioritised delivery plan, quantified trajectories, accountable programme governance, investment and disinvestment decisions, and consistent implementation across all ten places.

Key Controls
• Board-approved NHS GM Five Year Strategic Commissioning Plan 2026-2031, Clinical Strategy and Outcomes Framework.
• Strategic Commissioning Committee oversight, supported by Board reporting through the Strategic Commissioning Plan performance scorecard.
• Commissioning Delivery Group for oversight of delivery and escalation of risk
• Refreshed NHS GM Operating Model, Place Partnership Agreements, Place Outcomes, Place Fund and place teams.
• Neighbourhood Health and Live Well commissioning framework, locality neighbourhood plans and Prevention Demonstrator learning.
• Programme governance for primary care, healthcare commissioning, community services, population health, mental health, elective care, urgent and emergency care, digital and innovation.
• Provider collaboration through the Trust Provider Collaborative, Primary Care Provider Board and Alternative Provider Collaborative.
• Financial planning, contracting, procurement, market development and proposed outcomes/value-based commissioning mechanisms.
• GM data infrastructure, including the GM Care Record and analytical platforms, to support population health management and evaluation.
• Engagement and co-production with residents, clinicians, local government and VCFSE partners, underpinned by the GM VCFSE Accord.
• Quality, equality, clinical, financial and delivery impact assessment through programme and commissioning governance.

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- Commissioning Framework for 2027/28
- VCSFE Market Development Strategy

Gaps in Control or Assurance

- No single, fully quantified system-wide transformation portfolio linking activity shifts, capacity changes, cash-releasing savings, investment requirements and outcomes.
- Left Shift modelling methodology and longitudinal return-on-investment approach are not yet fully embedded across programmes and provider contracts.
- Limited assurance that resources can be moved from reactive acute provision to prevention and community services at the required pace without destabilising current services.
- Outcome measures, baselines, annual trajectories and benefits ownership are incomplete or not consistently applied

Approval of co-produced Market Development Strategy

across all programmes.

- Market capacity and sustainable funding for primary, community and VCFSE provision may be insufficient to absorb the planned shift in activity.
- Dependence on national policy, allocations, capital and contracting mechanisms remains only partly within NHS GM control.

Risk Scoring and Tolerance

	Inherent risk score	May 26	July 26	Sept 26	Nov 2026	Jan 27	March 27	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	4	4	4	4	3			3	2	
Impact	5	4	4	4	4			4	4	31 March 2031
Risk Level	20	16	16	16	12			12	8	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (6 – 12)	High (15 – 25)

Assurance	Assurance Level
Assurance level: partial / developing. Positive assurance is provided by the approved strategic plan, defined outcomes, governance routes, established place arrangements and programme infrastructure. Structures are now being filled and commissioning and programme teams embedded. However, assurance is not yet sufficient to demonstrate that transformation is fully quantified, resourced, contractually enabled and consistently deliverable across GM. The score should remain above tolerance until delivery trajectories, benefits, resources and accountabilities are evidenced.	**Partial**

Action	Complete/BAU	On Track

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			Delayed	Problematic
No	Action Required	Due Date	Progress	BRAG
1	Approve a single prioritised Strategic Commissioning Delivery Plan with named SROs, milestones, dependencies, outcome measures and escalation routes.	**30 June 2027**	Plan architecture to be aligned to the approved five-year plan and Board/Committee reporting cycle.	**On Track**
2	Complete and approve the GM Left Shift impact-modelling methodology covering activity, finance, workforce, quality, inequalities and population outcomes.	**31 Mar 2027**	Method is identified in the plan as a 2026/27 requirement; system agreement and consistent application are required.	**On Track**
3	Establish baselines and annual trajectories for investment moving to prevention, primary care, community and VCFSE provision, including benefits and disinvestment rules.	**31 Mar 2027**	Baseline and trajectory development required to evidence the intended shift in resource.	**Delayed**
4	Agree GM-wide commissioning, contracting and payment approaches that incentivise outcomes, prevention, collaboration and reduced pathway fragmentation.	**31 Mar 2027**	Options include outcomes-based and value-based mechanisms; implementation plan and early test areas required.	**On Track**
5	Implement regular update reports of delivery and risk from all thematic areas to the Commissioning Delivery Group to monitor progress and any risk to delivery.	**31 Jan 2027**	Establishment of the Commissioning Delivery Group in September with representation from Programme Directors, functional leads and Place Directors	**On Track**
6	Approval of the co-produced Market Development Strategy	**31 Mar 2027**	Ratification of the VCFSE Market Development Strategy aligned to priorities and outcomes of the 5 Year Strategic Commissioning Plan which will inform / shape the market to respond to the priorities	**On Track**

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Acting Chief Reform & Improvement Officer Report

November 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester
Strategic Commissioning Committee

November 2026

Required information	Details
Title of report	Acting Chief Reform & Improvement Officer Report
Author	Nicola Hepburn Acting Chief Reform & Improvement Officer, NHS GM Malcolm Whitehouse CDIO NHS GM, Dan Gordon Director Elective Care, NHS GM, Matt Hennessey, Chief Data and Analytics Officer NHS GM
Presented by	Nicola Hepburn Acting Chief Reform & Improvement Officer, NHS GM
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Executive summary	This report provides assurance on how NHS Greater Manchester Integrated Care Board is discharging its statutory duties for quality, safety and clinical governance across the organisation and the system as a whole. It brings together intelligence from established governance routes and demonstrates how statutory clinical governance and quality functions are being exercised to identify and manage risk, reduce unwarranted variation, and support safe, effective and equitable care across Greater Manchester. The report highlights key areas of assurance and oversight from the Reform & Improvement portfolio.
The benefits that the population of Greater Manchester will experience.	Continued support for performance oversight of health and care services, digital and data services delivery which enables effective healthcare delivery across the ICS
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy with the intention to deliver financial sustainability, improve our oversight arrangements with our commissioned providers and take forward our digital strategy.
The decision to be made and/or input sought	The Committee is asked to note the AAAA report and the position as of M6
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and progress made to improve these relate to BAF risk
Key milestones	These are set out within the different sections of the report.

Leadership and governance arrangements	This paper is produced for the Strategic Commissioning Committee and has not been elsewhere but is formulated from intelligence and papers from existing governance routes
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/approval by groups/committees.**	There has been no formal engagement on this paper as this paper is produced for the Strategic Commissioning Committee. The intelligence and papers used to formulate this report have come from the functions' workplans within the portfolio.
Financial or Legal Implications;	There are no direct new financial or legal implications arising from this report. Decisions with a material financial impact, including medicines optimisation and gainshare opportunities, are being progressed through the appropriate executive and financial governance routes in line with existing NHS GM policies. The report reflects continued work to improve patient standards and the ICB's delivery and improvement against the agreed strategic priorities.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
N	Y	N	N	N	N	Y

Table 2 – checklist of engagement carried out, advice sought, conflicts of interest and accessibility of the report

Alert

Elective Care

Elective performance has deteriorated, driven by the worsening position at the NCA. All other Trusts have submitted recovery plans to recover planned position but NCA have submitted a plan to get to 62% 18 week wait performance vs 67% plan. This relies on no further Industrial Action. Work is underway to agree other mitigating actions.

Urgent and Emergency Care

SCC

- Some areas remain dependent on provider-led arrangements, with potential gaps in accountability and delivery

H@H

- Delivery remains variable between providers.

In September 69.2% of patients attending ED were seen and treated within 4 hours compared to a plan of 74.9%. This was also a reduction from the period last year and this marks the first time where GM performance has seen a reduction compared to last year in 18 months.

9,731 (10.4%) of patients in ED waited in excess of 12 hours (type 1 and 2) against a plan of 6,618 (7.4%). There is continued focus on improving discharge, optimising flow and reducing long waits across urgent care pathways.

Digital and IT Services

The Committee should note that end-of-life devices and associated funding pressures remain the principal area of concern, Noting that in principle agreement to fund all critical operational pressures has been agreed but awaiting final Chief Officer sign-off. Continued difficulty recruiting specialist cyber security capacity also remains a material workforce consideration. We are progressing a risk managed delivery of a new EPR (Electronic Patient Record) entrant for GP services. A recovery plan for NCA end of life services is being progressed but is constrained by funding availability.

Progress against the ICB and provider 2026/27 Medium Term Plan headline measures

Over the past two weeks, the ICB and providers have been asked to strengthen delivery against headline measures during the second half of the year. The priorities are to achieve the elective RTT 18-week standard by November, recover UEC 4-hour performance by January, and improve the remaining measures over the year.

All trusts forecast delivery of the **18-week** milestone by the end of November, except NCA, which has not yet confirmed a recovery timescale. Across the wider 2026/27 **RTT, waiting-list and long-waiter measures**, the ICB forecasts performance below plan, largely due to under-delivery at NCA. All trusts have committed to meeting the **4-hour** target by March: MFT, NCA, Stockport and Tameside expect to return to plan in January, Bolton in February and WWL in March. October month-to-date performance shows that all trusts except WWL are behind both plan and forecast. All trusts committed to meeting the **62-day** target in each remaining month of the year, except Bolton and MFT. Bolton expects to return to plan by January and MFT by November. For the **28-day** target, all trusts expect to sustain delivery from October, except NCA, which expects to meet plan by January.

The ICB has enhanced its oversight of delivery. In addition, three GM providers have been placed in tiering arrangements: NCA and WWL for elective care, and Bolton for elective care, UEC, cancer and diagnostics.

NHS Oversight Framework
Publication of the ICB data was expected in August but remains outstanding.

Data, Insight & Intelligence (DII)

- Resource capacity and prioritisation remain a significant concern, with demand continuing to exceed available capacity across parts of the function.
- Compliance with the agreed governance process is inconsistent leading to scope creep and requirements confusion.
- Joint Controller Agreements remain an immediate issue: 57% of GP practices have signed. Data for secondary use has been stopped across nine practices, affecting population health reporting, with a risk that the number of affected practices could increase

Advise

Digital and IT Services
The Committee is invited to seek assurance that the financial and workforce risks affecting the GM Care Record, device replacement, core infrastructure and cyber resilience are being managed through the appropriate executive and financial governance routes.

Elective Care
GM Trusts currently have 41 elective Single Points of Access (SPOAs) live with a further 18 planned to go live in the coming weeks (Trusts required to deliver 10x SPOAs by the end of October 2026). In response to the recent HSSIB investigation report, Elective Programme focus is currently on Primary/Secondary care engagement through local interface groups, data capture and reporting of SPOA outcomes and quality assurance (including escalation and resolution processes). Delivery of Community Service expansion is challenged with some areas accelerating (Tameside, Stockport, Wigan - ENT) and others still in mobilisation stage (MFT, NCA, Bolton – ENT plus all areas for Gynaecology except MFT who are already mobilising).

UEC
SCC
Individual Patient Escalation
- Strengthening escalation arrangements for individual patients requiring additional support or intervention.
- Clarifying responsibilities, decision-making authority and escalation routes.
- Improving consistency across organisations and providers.

Care Coordination
- Aiming to reduce avoidable Emergency Department demand by improving access to alternatives in the community and out of hospital.
- Maintaining a single telephone access point and digital clinical triage.
- Standardising the model across localities and strengthening community capacity/opening hours.
- Improving direct booking, real-time capacity visibility and patient-level data.

Winter Event
- ICB Winter Event planned for November, bringing system partners together to maintain a strong focus on winter resilience and delivery.
- Focusing on operational pressures and priorities, including UEC performance, patient flow, discharge, capacity and escalation arrangements.
- Using the event to strengthen collective ownership of the winter plan, share good practice and agree actions to address emerging risks and pressures.

Mental Health
- Mental health and UEC working together to look at the opportunities to reduce long waits in ED via the Strategic Commissioning Committee (SCC) - sitting 4th Nov 2026.

- Recognising the Clinically Ready for Discharge (CRFD) numbers are increasing, looking at a system-wide approach and matrix working about what is causing the delays; this will support patient flow and ultimately reduce the long waits in ED.
- Recognising the variation in the mental health support to patients in acute medical beds – work ongoing.
- Real focussed areas to support improvement have seen a decrease in MH long waits in ED (waiting over 72 hours).
- Looking at opportunities via the UEC ED Long Waits audit (Nov 25) and ED 12-hour Waits (July 26), utilising the Getting It Right First Time (GIRFT) operational clinical standards for mental health patients in ED.

Financial Recovery & Improvement

Alongside the continued focus on achieving financial balance in-year, preparations are under way to address the challenges anticipated in 2027/28. Development of the 2027/28 Cost Improvement Programme has commenced, with a pipeline of potential opportunities already identified. The next phase will involve workshops across programme areas to support the co-production and timely development of schemes well in advance of the new financial year. Established PMO gateway processes will be used to support scheme development and provide appropriate oversight and assurance.

Data, Insight & Intelligence (DII)

- The Committee is asked to note the need for consistent application of the DII governance process across all functions. New products and significant resource requests should be reviewed through the DII Management Meeting, supported by agreed requirements and a Statement of Work, to reduce duplication, delays and scope creep.
- Over the next three months, DII will lead two priority programmes: the GM Data Collaboration and the NHS GM Data Quality Policy Programme.
    - The GM Data Collaboration will develop a clear and controlled framework for partner and third-party access to NHS GM data, products and technical services, including access routes, approvals, agreements, DII support and cost-recovery requirements. A proof of concept will help test and refine the approach.
    - The Data Quality Policy Programme will progress the NHS GM Data Quality Policy through approval and implementation, establishing consistent expectations, responsibilities, monitoring and escalation arrangements across NHS GM in response to recent MIAA audit requirements.

- NHS GM DII team has been identified as a key business critical contributor to the Prevention Demonstrator. DII input is required to shape the data-access, governance, technical, analytical and evaluation requirements with GMCA and wider partners including central government.

Assure

Elective Care

The Elective Recovery Team has developed a Demand Management dashboard to allow granular analysis of referral demand. Combined use of pre-referral A&G and referrals grew 5.6% but increased diversions from A&G and referral triage mean total accepted referrals grew c2% slightly ahead of 26/27 planning assumptions. Changes in referral practices have seen a larger growth in NHS Trusts with referrals decreasing into non-NHS providers. Work underway with referrers to highlight difference in waiting times and support informed patient choice. Finally, the impact of SPOA go-live from October will need to be monitored to assess whether impact is in line with modelled impact.

Digital and IT Services
The Committee can take assurance that core services remain operational, priority cyber alerts have been managed within required timescales, and GM Care Record security improvements are progressing. Programme delivery and formal closure activity also indicate continued portfolio control.

Financial Recovery & Improvement
The finalised ICB financial recovery plan was presented to the Board on Wednesday 21 October. It brings together operational cost run-rate pressures and CIP delivery risks, with the aim of achieving a balanced position by the end of the financial year. Particular focus is being given to All Age Continuing Care and Mental Health, the programme areas experiencing the greatest pressures. Both teams have developed programme-level recovery plans that feed into the wider ICB recovery plan. Established monitoring processes embedded by FES PMO has been updated to reflect the requirements of the recovery plans and has been communicated with teams to confirm. Progress will be reported through the Strategic Commissioning Committee to the Board, enabling emerging risks to be identified and mitigated promptly.

Progress against the ICB and provider 2026/27 Medium Term Plan headline measures

UEC
SCC
- Maintaining system oversight through regular monitoring, assurance checks and progress reviews.
- Continuing improvement work through recovery plans and performance trajectories.

H@H
- Reviewing previous evaluations to identify learning and improvement opportunities as to how these work and looking to increase use of Virtual Wards and support more flow and discharge from hospital.
- Maintaining oversight of utilisation and barriers to delivery.

NEPTS Procurement
- NEPTS Transition Group mobilisation is progressing, with governance, operational, contracting and finance arrangements being worked through to support a safe transition to the new service.
- Focus is now on closing outstanding mobilisation and demobilisation risks, ensuring clear ownership, actions and escalation so the service is ready for go-live.

Data, Insight & Intelligence (DII)
- TaskFlow has been successfully implemented as the centralised task-management system for DII, providing a single route for recording, tracking and overseeing demand and delivery.
- Internal governance processes are now in place for Management Meeting review of new products and cross-team resource requests, supported by standard templates including Statements of Work.
- DII SMT is developing a people and culture action plan, with staff training and Personal Development Plans actively progressing.

Risk discussed and new risk identified

Digital and IT Services Update
The end-of-life device risk remains escalated because replacement is constrained by funding and appropriately skilled resource capacity. The Committee should continue to scrutinise the adequacy of mitigations and the overall risk trajectory, including dependencies relating to disconnected devices, expiring infrastructure support, workforce vacancies and wider financial pressures.

UEC

SCC

- Main risk is variation between providers and reliance on arrangements that are not yet fully standardised.

Care Coordination

- Main risks are inconsistent delivery, system pressures and challenges demonstrating impact.

Elective Care

Elective team has been carrying 1x programme manager vacancy since the end of March, this is increasing to 3x from the end of December due to programme managers securing new roles. This means 75% of programme manager roles (50% of delivery team) will be vacant from the end of the year. Even with successful recruitment we expect a significant gap in team capacity, and loss of knowledge and expertise challenging programme deliverability from Q4.

Data, Insight & Intelligence (DII)

- Capacity and prioritisation remain key delivery risks. Without consistent use of TaskFlow, Statements of Work and the agreed approval routes, there is an increased risk of unclear scope, delayed delivery, duplicated products and unplanned pressure on teams.
- Not all stakeholder groups required by the DII operating model have been implemented, due to ongoing Reform programme. DII will attend the Place Partnership Group on 3 November 2026 to agree the requirements for a Place annual work plan, priorities and the route for contacting locality DII teams.
- Joint Controller Agreement completion remains a material data-access risk. With 57% of practices signed and secondary-use data currently stopped across nine practices, there is an impact on population health reporting and a risk of further interruption if practice engagement does not secure the outstanding agreements.
- The Prevention Demonstrator requires early clarity on NHS GM's role, scope, governance, funding and resource contribution. Without this, DII requirements may be identified too late or absorbed into existing capacity, affecting the establishment of the required data-sharing, technical and analytical arrangements.

Achievements

Digital and IT Services

- The Committee is asked to note approval of the ICB Copilot delivery and digital transformation plan, continued development of the GM Health and Care Digital Strategy, targeted device replacement, and further delivery and closure across the Digital and IT programme portfolio.

Elective Care

The Elective Team has now completed a comprehensive investment review for Consultant Connect Specialist Advice platform. This is a full evaluation of CC implementation and impact since October 25 including Primary Care feedback, diversion impact and contract performance. This will be presented to Elective Board on 21st October.

UEC

Falls Lifting

- Over Winter - This is to reduce ambulance call-outs and improve response times for people who have fallen but are not injured.
- Service is now live and responding to appropriate falls cases.

Data, Insight & Intelligence (DII)

- Successful implementation of TaskFlow as DII's centralised task-management system.
- Agreement of the NHS GM Data Quality Policy and supporting implementation planning.
- DII work nationally recognised at the MCA Awards 2026 CF with Boehringer Ingelheim - MCA

NHS
Greater Manchester

Chief Strategy, People and Partnerships Officer - Alert Report

November 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

NHS Greater Manchester Strategic Commissioning Committee

October 2026

Required information	Details
Title of report	Chief Strategy, People and Partnerships Officer - Alert Report
Author	Paul Lynch, Jonathan Kerry, David Boulger
Presented by	Charlotte Bailey, Chief Strategy People and Partnerships Officer
Contact for further information	Charlotte.bailey37@nhs.net
Executive summary	This paper alerts, assures and advises the Committee regarding key priorities, risks and mitigations relating to; - Live Well - Population Health Transformation - Place Partnerships development - Neighbourhood health plans All programmes are currently on track.
The benefits that the population of Greater Manchester will experience.	Develop and deliver a programme of work to improve health outcomes and enable the left shift towards prevention and care closer to home.
How health inequalities will be reduced in Greater Manchester's communities.	Develop and deliver a programme of work to improve health outcomes for all and further facilitate the left shift towards prevention and care closer to home.
The decision to be made and/or input sought	The SCC is asked to: Note the report
How this supports the delivery of the strategy and mitigates the BAF risks	SR1, SR4 and SR5 by reducing demand drivers, improving resilience in communities, and narrowing inequalities
Key milestones	Locality Boards will consider the proposed Place Partnership arrangements during October 2026. NHS Greater Manchester and Greater Manchester Combined Authority will share

	learning on Live Well, Neighbourhood Health and prevention with the Department of Health and Social Care senior team during October 2026. Place Partnership Agreements are expected to be approved and signed in November 2026. Hosting Services Contracts are expected to be approved and signed in December 2026. Place Partnerships will begin operating in shadow form from 1 January 2027, supported by local mobilisation and workforce transfer activity. Testing of a single Place assurance narrative will begin during Quarter 4 of 2026/27, bringing together data, intelligence, delivery information and professional judgement. The Place assurance approach is expected to be fully established during Quarter 1 of 2027/28. Place Fund and Section 75 arrangements will come into effect from 1 April 2027. The Population Health transformation programme is planned to go live from 1 April 2027. Work is ongoing to bring together baseline information from all ten Places to support quarterly outcomes reporting. Work will continue to develop interactive Neighbourhood Health Packs, enhance the Health Profiles Dashboard, and strengthen projected demand and Place baseline information. A dedicated workstream is also developing and testing commissioning and contracting

	approaches to better support neighbourhood health outcomes.
Leadership and governance arrangements	This paper is produced for this committee and has not been elsewhere.
Engagement to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	System-wide engagement is complete: 280 feedback points were considered from 26 submissions or source documents across 24 organisations, Places or teams. Contributors included Place and system partners, Chief Officers, Place Leads, Place Partnership Directors, primary care, trade unions, receiving organisations and affected staff.
Financial or legal implications	Financial and legal implications relate to the Place Partnership Agreement, Hosting Services Contract, Place Fund, Section 75 and workforce transfer arrangements. These will be subject to finance, legal, workforce and governance assurance. Partners retain their statutory, financial, contractual, clinical, quality, safeguarding, workforce and regulatory responsibilities. Material issues will be escalated through the appropriate governance route.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
N	N	N	N	N	N	Y

Table 1 - checklist of engagement carried out, advice sought, conflict of interest and accessiblity of report

NHS
Greater Manchester

Key Updates and Escalations

Alert
Place Partnerships: Nothing for October **Neighbourhood Health:** Nothing for October **Population Health:** Nothing for October
Advise
Place Partnerships: The Place Outcome report contains an update on progress to establish consistent arrangements for Place Partnerships to oversee and provide assurance on delivery of the Place Outcomes Framework. The proposed approach places collective accountability with Place Partnership Boards, using performance evidence, local intelligence and professional judgement to assess progress, delivery confidence, risks and required improvement action. This will inform assurance to the Strategic Commissioning Committee and NHS Greater Manchester Board, while using existing Place governance and reporting arrangements wherever possible. Work is underway to develop an end-to-end operating process, a standard Place Outcomes Assurance Statement and the supporting intelligence arrangements. The approach will be tested and refined during Q4 2026/27, with routine implementation planned from Q1 2027/28, subject to learning and readiness. The Committee is asked to note progress and agree to receive monthly updates, with a substantive update in February 2027. **Neighbourhood Health:** Each locality has completed an updated Neighbourhood Health Plan and submitted this to the GM Strategy Team. A working group has been established with representation from place and the Strategy and Data, Insight and Intelligence Teams. Its key task is to develop a set of data products to support our plans for Neighbourhood Health. This includes: • Interactive versions of Neighbourhood Health Packs. This will enable users to explore and analyse neighbourhood-level information in a more flexible and user-friendly way.

- Health Profiles Dashboard. The updated dashboard will feature neighbourhood-level analysis, enabling users to explore population demographics, health needs and service utilisation at a more granular geographical level.
- Projected Demand Growth and Place Baselines. This will enable Place Based Partnerships to understand the scale of the challenge within their populations and develop locally led solutions to address future demand.

Population Health:
Nothing for October

Assure

Place Partnerships:

The document suite has completed system-wide engagement, multidisciplinary review and Executive Committee approval, providing a common Greater Manchester framework with local flexibility and retained partner responsibilities.

Mobilisation is progressing through October Locality Board consideration, November Partnership Agreement approval and signing, and December Hosting Services Contract approval and signing. Place Mobilisation Groups are coordinating governance, workforce, finance, digital, estates, information governance and service-transfer readiness for shadow operation from 1 January 2027.

Neighbourhood Health:

Last month, we provided an update on NHS GM's response to the NHS England consultation on Single Neighbourhood Provider (SNP) and Multi-Neighbourhood Provider (MNP) contracts. Our response welcomed the overall ambition but also highlighted the opportunity for GM to build on our existing strengths and develop a bespoke approach that reflects our wider ambitions for neighbourhood health, Live Well, prevention and public service reform. To accelerate our progress, we are establishing a workstream to enable us to design and test the commissioning and contracting models that best support the outcomes we want to achieve, rather than starting with a predetermined contractual form. Chief Officers supported this approach at a meeting in September.

Population Health:

The Population Health Network transformation proposal is now fully completed and is ready for formal approval through NHSGM Committees and Board. A full paper presents this in detail and therefore an update is not provided with this report.

Risks discussed and new risks identified

For oversight and assurance, the table below provides an overview of the risk log, including current controls, mitigations and priority actions which have recently been updated. Going forward, the report will focus on risks with a score of 16 or above.

Ref	Risk Details	Current Score (LxI)	Key Mitigations / Controls	Priority Actions
NH: 001	Insufficient alignment and collective commitment between partners may limit system-wide delivery of the Neighbourhood Model, causing delayed decisions, fragmented approaches, duplication and reduced use of collective resources.	12 (3x4)	Strategic Commissioning Plan and core neighbourhood standards; strengthened Place Partnership governance; joint planning and priority-setting; shared outcomes through the Place Outcomes Framework; collaborative leadership and engagement.	Finalise the Place Partnership document suite and Place Assurance Process; implement Neighbourhood Health Plans with clear governance; continue alignment with the Trust Provider Collaborative, Primary Care Board and GMCA.
NH: 002	Unclear accountability and decision-making responsibilities across system, Place, provider and neighbourhood levels may lead to delays, duplication, inconsistent decisions and ineffective escalation.	12 (3x4)	Governance structures, terms of reference and schemes of delegation through the NHS GM Operating Model and Place Partnership agreements; agreed escalation routes; defined roles; formal recording and monitoring of decisions and actions.	Clearly define delegated authority, clinical accountability, financial responsibility and decision-making rights across ICB, Place, provider collaborative and neighbourhood levels.
NH: 003	Financial pressures may limit investment in and sustainability of the transformation needed to deliver the Neighbourhood Model, reducing scale, delaying implementation and destabilising services during transition.	16 (4x4)	Aligned financial planning through Place Partnership Board and Place Fund; system oversight through PRC; financial monitoring and forecasting; phased implementation; governance and escalation of significant financial pressures.	Develop and implement a system-wide investment, resource allocation and benefit-sharing approach, including management of double-running and stranded costs, phased investment, joint financial planning and benefits realisation.
NH: 004	Commissioning and contracting arrangements may not support sustainable neighbourhood-based services, resulting in fragmented pathways, reduced collaboration and provider instability.	9 (3x3)	Place Partnership input to contract design; maturing provider collaboration; contract performance and sustainability monitoring through POMs; a single NHS GM response to national neighbourhood contracts; financial oversight through PRC and SCC.	Establish a consistent neighbourhood commissioning framework that aligns contracting, payment, procurement and funding arrangements and strengthens long-term sustainability.
NH: 005	Insufficient workforce capacity and capability may limit sustainable neighbourhood delivery, causing inconsistent coverage, unsustainable	9 (3x3)	Place Partnership and PRC oversight; workforce and vacancy monitoring; recruitment and retention activity; learning and development; wellbeing	Progress a system-wide workforce approach aligned to the Neighbourhood Model, clarifying requirements and employment arrangements, addressing priority gaps and

	caseloads, workforce pressure and risks to quality and access.		support; professional governance; collaborative workforce planning; system organisational development and leadership plans.	enabling flexible deployment across organisational boundaries.
NH: 006	Insufficient digital and data capability may limit integrated neighbourhood working, causing fragmented care, delayed decisions, duplication, ineffective targeting and digital exclusion.	9 (3x3)	NHS GM Digital Strategy planned for January 2027; GM Care Record and Secure Data Environment; information governance and data-sharing agreements; digital transformation; population health analytics; cyber, clinical safety and digital assurance; digital inclusion support.	Progress interoperability, shared record access, information sharing and population health capability, while addressing digital exclusion and variation in capability.
NH: 007	Neighbourhood working may not deliver equitable access and outcomes and could widen health inequalities where intelligence, co-production and service design do not reflect differing needs and barriers.	12 (3x4)	Health equality within the Place Outcomes Framework and Place Assurance; population health intelligence and Integrated Needs Assessments; SCC and PRC oversight; equality impact assessments; community engagement and co-production; monitoring of access and outcomes.	Embed an inequalities-focused approach using population health intelligence, equality impact assessment and community co-production to identify unmet need, remove access barriers and target interventions.

Learning for sharing

Achievements

Place Partnerships:

Following eight weeks of partner engagement, a four-week sprint methodology enabled the Place Partnership document suite to be finalised in response to 280 feedback points from 26 submissions or source documents across 24 organisations, Places or teams. The approach brought together multi-professional and multi-organisational perspectives through time-limited, subject matter specialist-led document cells, allowing different parts of the suite to be revised in parallel while maintaining coordination across the whole programme.

A key learning was the value of combining a clear timeframe and defined responsibilities with a single, structured record of feedback, decisions and drafting actions. Feedback was grouped into themes and allocated to the relevant cells, enabling contributors to consider the issues together rather than through successive rounds of separate correspondence. Regular coordination supported the identification and escalation of cross-cutting issues, while checks across the suite helped prevent amendments to one document from creating inconsistencies elsewhere. Recording the response and rationale also provided transparency about how feedback had informed the final documents.

The transferable learning is that pace and inclusive engagement can be achieved together when specialist input, drafting support and programme coordination are organised around a shared task. The sprint provided a disciplined route from extensive feedback to a coherent document suite, which received Executive Committee approval on 14 October 2026. Importantly, it distinguished matters that could be resolved through document amendments from those requiring further local decisions, contractual development or mobilisation activity. This offers an approach for other complex partnership programmes: use focused, parallel working to reach an agreed position, while keeping outstanding dependencies visible and preserving the appropriate assurance and approval processes.

Example of good practice

Bolton's Short-Term Care (STC) redesign demonstrates the benefits of place-based partnership working, with Bolton Council, Bolton NHS Foundation Trust and NHS Greater Manchester (Bolton) working as a single system to redesign services around the needs of local residents. Through shared data, joint financial planning and collective decision-making, partners developed a more sustainable and effective model of community-based care.
The redesigned service improves outcomes for residents by supporting recovery closer to home, reducing unnecessary hospital admissions and enabling more timely discharge from hospital. The model also addresses a recognised gap in provision through the creation of an eight-bed dementia unit, while dedicated discharge facilitators help individuals and families plan safe and supported returns home.
The programme demonstrates how integrated working can improve outcomes while releasing resources for reinvestment. Approximately £180,000 per annum is being redirected into voluntary and community sector support, strengthening Discharge to Assess at Home arrangements and helping people maintain independence through practical and social support in their own communities.

Neighbourhood Health:

NHS GM and GMCA were approached by the Department of Health and Social Care to share our learning on Live Well, Neighbourhood Health and the Prevention Demonstrator. This resulted in a meeting with the DHSC Permanent Secretary (Sam Jones) in September where we highlighted our progress. As a follow up, we will be attending one of the DHSC senior team sessions in October to share this learning more widely.

Population Health:

None for October

NHS
Greater Manchester

Performance Report 2026-2027

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Strategic Commissioning Committee

November 2026

Required information.	Details.
Title of report.	Performance Report
Author.	Zoe Mellon, Associate Director of Performance
Presented by.	Ed Dyson – Director of Performance, Improvement & Assurance Nicola Hepburn – Acting Chief Reform and Improvement Officer
Contact for further information.	Zoe Mellon (zoe.mellon@nhs.net)
Executive summary.	This report provides an update on Greater Manchester's (GM) progress in achieving NHS operational planning goals, outlines significant risks faced by our providers along with key improvement actions.
The benefits that the population of Greater Manchester will experience.	Achievement of performance objectives will improve access to services and drive up standards of care for the Greater Manchester population.
How health inequalities will be reduced in Greater Manchester's communities.	Ensuring delivery of standards across Greater Manchester Trusts will equalise geographical variation.
The decision to be made and/or input sought.	This paper is for assurance and discussion allowing the committee to agree levels of assurance and identify any further actions.

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This supports delivery of operational planning and constitutional standards.
Key milestones.	Monthly and quarterly milestones are in place.
Leadership and governance arrangements.	This paper is for Strategic Commissioning Committee only.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Engagement is undertaken within various programmes contributing to performance delivery.
Financial or Legal Implications	

Table 1: Information needed about the document and its purpose.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of interest	Report accessibility	EHIA
No	No	No	No	No	No	Yes	No

NHS
Greater Manchester

Strategic Commissioning Committee Performance Report

November 2026

Part of Greater Manchester Integrated Care Partnership

Executive Summary

NHS Greater Manchester

Overall position

- 9 Alert, 3 Advise and 5 Assure metrics.
- Key risks remain within UEC, Elective Care, Diagnostics, Mental Health, and Learning Disability and Autism.
- The overall position supports a recommendation of partial assurance
- H2 recovery arrangements are in place for Elective, UEC, Cancer and Diagnostics. Revised provider trajectories and recovery actions are being monitored through established system governance, with delivery risk remaining greatest within UEC and Elective Care.

Alert (focused system oversight)

- UEC: 4-hour and 12-hour A&E performance remain off plan, reflecting continued patient flow and discharge pressures.
- Elective: The total waiting list remains above plan and is a material risk to the year-end trajectory.
- Diagnostics: The percentage of patients waiting six weeks or more is above plan and is rated Alert.
- Mental Health: Talking Therapies reliable recovery, reliable improvement and completed courses remain below plan; inappropriate out-of-area placements remain above plan.
- Learning Disability and Autism: Inpatient care for autistic adults remains rated Alert and requires focused oversight, with inpatient numbers remaining above plan.

Advise (continued oversight)

- RTT 18-week performance remains below plan and requires continued oversight.
- Cancer 28-day Faster Diagnosis Standard and 62-day treatment performance remain below plan.
- These three metrics require continued oversight against plan and trajectory.

Assure (on track / stable delivery)

- Category 2 ambulance response times, 31-day cancer treatment, Individual Placement Support activity, inpatient care for adults with a learning disability and community waiting times are rated Assure.

Key achievements

- Five headline metrics are rated Assure, including Category 2 ambulance response times, community waiting times, IPS activity, 31-day cancer treatment and inpatient care for adults with a learning disability.
- Individual Placement Support activity, community waiting times and inpatient care for adults with a learning disability remain on track against plan.
- Category 2 ambulance response times remain below the 25-minute national target.

Ask of the meeting

The meeting is asked to note

- the current performance position, key delivery risks and areas requiring focused system oversight, and highlight any further actions required to support recovery.

2026/27 ICB Headline Planning Metrics (SCC oversight)

NHS Greater Manchester

These metrics define the core measures underpinning the Alert / Advise / Assure framework and system oversight for 2026/27

ICB										
Area	KPI	Period	Actual	Plan	Variance (latest **published** data vs same period in previous year)			ICB Benchmarking (**published** data)		
					2025	Variance	Movement	Aug-25	Aug-26	Movement
Elective	Percentage of RTT waiting list within 18 weeks	Aug-26	63.0%	64.7%	55.8%	7.2%	↑	34/36	31/36	↑
	Total waiting list	Aug-26	411,464	352,213	426,679	-15,215	↓			
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Aug-26	14.4%	11.5%	18.5%	-4.1%	↓	9/36	6/36	↑
Cancer	28-day cancer Faster Diagnosis Standard	Aug-26	78.5%	79.8%	76.1%	2.4%	↑	16/36	21/36	↓
	Percentage of patients receiving a first definitive treatment for cancer within 62 days	Aug-26	75.7%	76.7%	71.8%	3.9%	↑	13/36	9/36	↑
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days	Aug-26	96.6%	93.7%	96.3%	0.3%	↑	5/36	7/36	↓
Mental Health	NHS Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness	Jul-26	46.2%	51.0%	43.6%	2.6%	↑	34/36	23/36	↑
	NHS Talking Therapies: Reliable improvement rate for those completing a course of treatment	Jul-26	67.8%	69.0%	63.4%	4.4%	↑	35/36	23/36	↑
	NHS Talking Therapies: No. completed courses of treatment (YTD)	Jul-26	3,045	3,846	3,045	0	↔			
	Number of patients accessing Individual Placement Support services (12-month rolling metric)	Aug-26	4,785	3,240	2,805	1,980	↑			
	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period (local data)	Aug-26	4	2	3	1	↑			
Learning Disability and Autism	Inpatient care for Adults with Learning Disabilites (who may also be autistic)	Aug-26	40	42	45	-5	↓			
	Inpatient care for Autistic Adults (with no learning disability)	Aug-26	60	48	55	5	↑			
Community Health Services	Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less	Aug-26	86.9%	82.1%	83.2%	3.7%	↑			

2026/27 GM Provider Headline Planning Metrics (SCC oversight)

NHS Greater Manchester

GM Providers / Ambulance Trust							
Area	KPI	Period	Actual	Plan	Variance (latest **published** data vs same period in previous year)		
					2025	Variance	Movement
Urgent and Emergency Care (UEC)	CAT 2 ambulance response times	Sep-26	00:19:57	<00:25:00	00:22:35	-00:02:38	↓
	4-hour A&E performance	Sep-26	69.2%	74.9%	70.1%	-0.9%	↓
	12-hour A&E performance (type 1&2)	Sep-26	10.2%	7.5%			
Elective	Percentage of RTT waiting list within 18 weeks	Aug-26	61.5%	63.5%	54.7%	6.8%	↑
	Total waiting list	Aug-26	441,682	412,948	467,135	-25,453	↓
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Aug-26	14.2%	9.8%	19.4%	-5.2%	↓
Cancer	28-day cancer Faster Diagnosis Standard	Aug-26	78.5%	80.1%	76.3%	2.2%	↑
	Percentage of patients receiving a first definitive treatment for cancer within 62 days	Aug-26	76.4%	76.9%	71.8%	4.6%	↑
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days	Aug-26	96.8%	94.6%	95.9%	0.9%	↑

These metrics define the core measures underpinning the Alert / Advise / Assure framework and system oversight for 2026/27

26/27 Alert, Assure and Advise framework

NHS Greater Manchester

Area	Metric	Alert	Advise	Assure
Urgent and Emergency Care (UEC)	CAT 2 ambulance response times			
	4-hour A&E performance			
	12-hour A&E performance			
Elective	Percentage of RTT waiting list within 18 weeks			
	Total waiting list			
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over			
Cancer	28-day cancer Faster Diagnosis Standard			
	Percentage of patients receiving a first definitive treatment for cancer within 62 days			
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days			
Mental Health	NHS Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness			
	NHS Talking Therapies: Reliable improvement rate for those completing a course of treatment			
	NHS Talking Therapies: No. completed courses of treatment (YTD)			
	Number of patients accessing Individual Placement Support services (12-month rolling metric)			
	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period			
Learning Disability and Autism	Inpatient care for Adults with Learning Disabilites (who may also be autistic)			
	Inpatient care for Autistic Adults (with no learning disability)			
Community Health Services	Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less			

NHS
Greater Manchester

Appendices

Domain Performance – Elective Care & Diagnostics

Narrative provided for alerts only

NHS Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	• August 2026: two Alert metrics, total waiting list and diagnostic waits of six weeks or more (DM01). • Total waiting list: GM providers 441,682 against 412,948 plan. ICB 411,464 against 352,213 plan. • DM01: providers 14.2% against 9.8% plan. ICB 14.4% against 11.5% plan. Both worsened in August. • Referral to Treatment (RTT) within 18 weeks remains Advise: providers 61.5% against 63.5% plan. ICB 63.0% against 64.7% plan.	• August waiting list growth widened the recovery gap. Diagnostic waits also rose, interrupting improvement. • Community Services: MFT and Northern Care Alliance (NCA) implementation remains delayed. MFT has recruited to expand its service. NCA has an independent-sector agreement for 2026/27. Funding, contracting and SPoA decisions remain dependencies. • Single Point of Access (SPoA): delivery varies. WWL and NCA are furthest behind, with three and two SPoAs live respectively. Risks include triage capacity, referral-system functionality and diagnostic responsibilities. • Place team capacity, inconsistent referral-scheme interpretation and advice quality remain risks. • Cardiac CT review extended to end October. Finance may limit options. Testing enhanced diagnostic attendance data remains delayed.	• Provider H2 trajectories and associated recovery actions are being reviewed through the Elective Recovery Task and Finish arrangements, with particular focus on delivery against RTT, waiting-list and long-wait commitments. • Elective Recovery Board oversight continues. The revised Beyond Core Contact Review scheme retains 10% growth in Advice and Guidance (A&G) use, removes the linked referral-reduction requirement and redirects funding to quality improvement and engagement. • Consultant Connect review completed. Support for low uptake and clinical audit will strengthen A&G quality. Community ear, nose and throat and gynaecology pathways include interim independent-sector capacity. • SPoA priorities: operational readiness, consistent triage standards, outcome reporting and support for services not yet live. • Diagnostics: cardiac CT review by end October, THRIVE productivity work and improved booking towards a maximum 5% missed-appointment rate, focusing on audiology. • Standardise gastroenterology pathways and validate endoscopy surveillance lists. Sonography workforce review by December and a 3–5 year plan by March 2027.	SR2

Elective Care and Diagnostics has two Alert metrics: total waiting list and DM01. Both provider and ICB positions are worse than plan, with August deterioration despite improvement over the previous year. RTT remains Advise. Priorities are recovery trajectories, consistent community and SPoA delivery, the revised referral scheme, and diagnostic capacity, productivity and pathway improvements.

Domain Performance – Urgent and Emergency Care (UEC)

Narrative provided for alerts only

NHS Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	• Two Urgent and Emergency Care metrics remain Alert in September 2026. • 4-hour performance: 69.2% against a 74.9% plan, with deterioration in the latest month. • 12-hour waits: 10.2% against a 7.5% plan. 9,728 patients waited 12 hours or more, up on the previous month. • Category 2 ambulance response: 19 minutes 57 seconds, within the plan of under 25 minutes.	• Provider shortfalls remain widespread for 4-hour performance. Several providers remain off trajectory for 12-hour waits. • Data quality, reporting delays and intelligence gaps constrain early identification of deterioration. • Individual patient escalation routes have gaps in accountability and decision-making across providers, Place and the Integrated Care Board. • Community capacity, interoperability and variable delivery across localities and providers remain risks to improvement.	• Provider H2 recovery trajectories for four-hour and 12-hour performance are being monitored through the UEC recovery arrangements, with focused review of delivery against forecast and the actions required where providers remain off plan. • System Coordination Centre oversight continues through Operational Pressures Escalation Levels (OPEL) monitoring. The Greater Manchester OPEL Escalation, Surge and Recovery Framework is due for operational lead review in October and planned launch in November 2026. • A multi-agency workshop will review individual patient escalation across all cohorts, including emergency department waits, ward delays and discharge. It will clarify responsibilities, escalation routes and follow-up. • Care Coordination and the Single Point of Access will standardise local models, strengthen community capacity and progress direct booking. Hospital at Home evaluation reviews will identify opportunities to increase utilisation and support earlier discharge. Both programmes remain Amber. • The Greater Manchester Falls Lifting Service went live on 1 October 2026 and runs until 31 March 2027 to support non-injured fallers at home. Status: Green.	SR2

September performance remains Alert: 4-hour performance is 5.7 percentage points below plan and 12-hour waits are 2.7 percentage points above plan. Category 2 ambulance response remains within plan. Improvement priorities are stronger system oversight and patient escalation, more consistent community alternatives and increased Hospital at Home utilisation. The Falls Lifting Service is now live. Most programmes remain Amber, with delivery dependent on partner engagement, capacity and clearer accountability.

Domain Performance – Cancer

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No Alert metrics for Cancer in August 2026. The 28-day Faster Diagnosis Standard and 62-day treatment measures remain rated Advise and will continue to be monitored through Cancer Alliance governance. The 31-day measure remains Assure.

Domain Performance – Mental Health & Learning Disabilities and Autism

Narrative provided for alerts only

NHS Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	BAF risks
Alert	• Five Mental Health and Learning Disability & Autism metrics are rated Alert: NHS Talking Therapies reliable recovery, reliable improvement and completed courses of treatment, inappropriate adult acute Out of Area Placements, and inpatient care for autistic adults without a learning disability. • Data note: The overall Greater Manchester position uses July data for all three Talking Therapies measures. Greater Manchester Mental Health NHS Foundation Trust did not publish August data for these measures.	**Mental Health:** Talking Therapies reliable recovery and activity remain below plan, although provider reporting indicates strengthening performance for newer referrals. Internal treatment flow remains challenging, including extended waits between first and second treatment appointments. Inappropriate Out of Area Placements continue to require system oversight, with capacity, flow and discharge pressures remaining key risks. **Learning Disability & Autism:** Performance is mixed across the two inpatient measures. Adults with a learning disability remain below plan at 40 inpatients against a plan of 42, reflecting continued progress in reducing reliance on inpatient care. However, autistic adult inpatient numbers remain above plan at 60 against a plan of 48 and continue to present a delivery risk. Delivery remains constrained by insufficient community alternatives and step-down capacity, together with barriers to timely discharge, placement and commissioning decisions.	• Continued oversight through Mental Health governance and assurance arrangements. • Targeted improvement work to support Talking Therapies recovery, improvement and activity measures. • Continued focus on reducing inappropriate Out of Area Placements through improved discharge planning and community alternatives. • Ongoing work to sustain progress in learning disability inpatient care and reduce autistic adult inpatient reliance through crisis support, admission avoidance and step-down provision.	SR2

Mental Health and Learning Disability & Autism has five Alert metrics relating to NHS Talking Therapies performance, inappropriate Out of Area Placements and inpatient care for autistic adults. Performance continues to present delivery risks across outcomes, capacity and patient flow. System actions remain focused on improving Talking Therapies outcomes, reducing Out of Area Placements and reducing autistic adult inpatient reliance through strengthened community alternatives and discharge arrangements.

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Place Partnerships: Outcomes, Oversight and Assurance

Part of Greater Manchester
Integrated Care Partnership

NHS
Greater Manchester

Strategic Commissioning Committee

Required information	Details
Title of report	Place Partnerships: Outcomes, Oversight and Assurance
Author	Jo Street- Programme Director
Presented by	Jo Street- Programme Director
Contact for further information	Jo Street- Programme Director
Executive summary	This report updates progress in establishing arrangements for Place Partnerships to report and provide assurance on delivery of the Place Outcomes Framework. The approach places collective accountability with Place Partnership Boards, bringing together evidence, intelligence and judgement on outcomes, delivery confidence, risks and improvement action to inform assurance to Strategic Commissioning Committee and NHS Greater Manchester Board. It is intended to use existing Place governance and evidence wherever possible, rather than create a parallel performance-management process. An end-to-end operating process and Place Outcomes Assurance Statement are being developed alongside supporting outcomes intelligence and reporting arrangements. Testing and refinement are proposed during Q4 2026/27, ahead of routine operation from Q1 2027/28, subject to learning and readiness of the supporting intelligence arrangements.
The benefits that the population of Greater Manchester will experience.	The proposed arrangements will support better outcomes for Greater Manchester residents by strengthening partners' collective focus on delivery of agreed Place priorities. Bringing together evidence and local intelligence will help identify where progress is off track, enable timely improvement action and share learning across Places. Clearer accountability and assurance will help partners and NHS Greater Manchester

	understand whether action is making a difference for communities and where additional support is needed.
How health inequalities will be reduced in Greater Manchester's communities.	The proposed arrangements will support a clearer focus on health inequalities by enabling Place Partnerships to consider differences in outcomes between communities, rather than relying solely on overall Place-level performance. Bringing together quantitative evidence and local intelligence should help identify where inequalities persist or widen, inform targeted improvement action and assess whether that action is making a difference.
The decision to be made and/or input sought	The Committee is asked to: • **note** the Place Outcomes Framework and Place Governance, Accountability, Oversight and Assurance Framework attached as appendices; • **note** progress in translating the agreed framework into practical operating arrangements for Place outcomes assurance; • **note** the proposed approach to testing and refining these arrangements during Q4 2026/27; and • **agree** to receive progress updates through the monthly SPP AAAA report, with a substantive update in February 2027.
How this supports the delivery of the strategy and mitigates the BAF risks	The proposed arrangements support delivery of the strategic priorities for prevention, population health improvement and neighbourhood care, and contribute to mitigating SR1- Population health improvement and reducing inequalities and SR5- system collaboration.
Key milestones	1. PHCP Document Suite approved via Executive Committee 16.10,26 2. Development of operational level plan for oversight of Place Outcomes to be completed by end Q3 2026/27 3. Trialling and adapting the operational level plan for oversight of Place Outcomes to take place during Q4 2026/27 4. Launch of oversight arrangements of Place Outcomes Q1 2027/28.
Leadership and governance arrangements	This work is being led by the Place Outcomes and

	Oversight Workstream. The workstream is part of the overall PHCP Mobilisation Programme. This programme is led jointly by the Programme Director for Reform and Transition and the lead Place Partnership Director for PHCP development. The Chief Strategy, People and Partnerships Officer is the SRO for the programme.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The Place Health and Care Partnership Document Suite has been subject to system partner engagement through its development stages. The Place Outcomes Framework and Place Governance, Accountability, Oversight and Assurance Framework have therefore been part of this engagement. The implementation progress described in this report have been developed through engagement and multi-professional working internally only at this stage.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
N	N	N	N	N	N	Y

Table 1 - checklist of engagement carried out, advice sought, conflict of interest and accessiblity of report

1. Purpose

To update the Strategic Commissioning Committee on progress in establishing the arrangements through which Place Partnerships will report and provide assurance on delivery of the Place Outcomes Framework, and to set out the next steps towards implementation.

2. Background

The Place Outcomes Framework and Place Governance, Accountability, Oversight and Assurance Framework form part of the wider Place Health and Care Partnership (PHCP) document suite. The suite establishes the common framework for how Place Partnerships will operate across Greater Manchester, while allowing flexibility for individual Places to reflect their local arrangements.

The Place Outcomes Framework defines the outcomes PHCPs seek to improve and provides the shared basis for measuring progress and collective assurance. The Place Governance, Accountability, Oversight and

Assurance Framework provides the common architecture through which partnership governance, resources and hosting, and assurance on delivery of those outcomes connect.

The complete PHCP document suite has been considered through Executive Committee and subsequently issued as the final suite to Place Leads and Place Partnership Directors to progress partner sign-off.

The two frameworks particularly relevant to this paper are attached for the Committee's information:

- Appendix 1: Place Outcomes Framework
- Appendix 2: Place Governance, Accountability, Oversight and Assurance Framework

Together, these establish both what Place Partnerships are seeking to achieve and how progress, collective accountability and assurance will be understood.

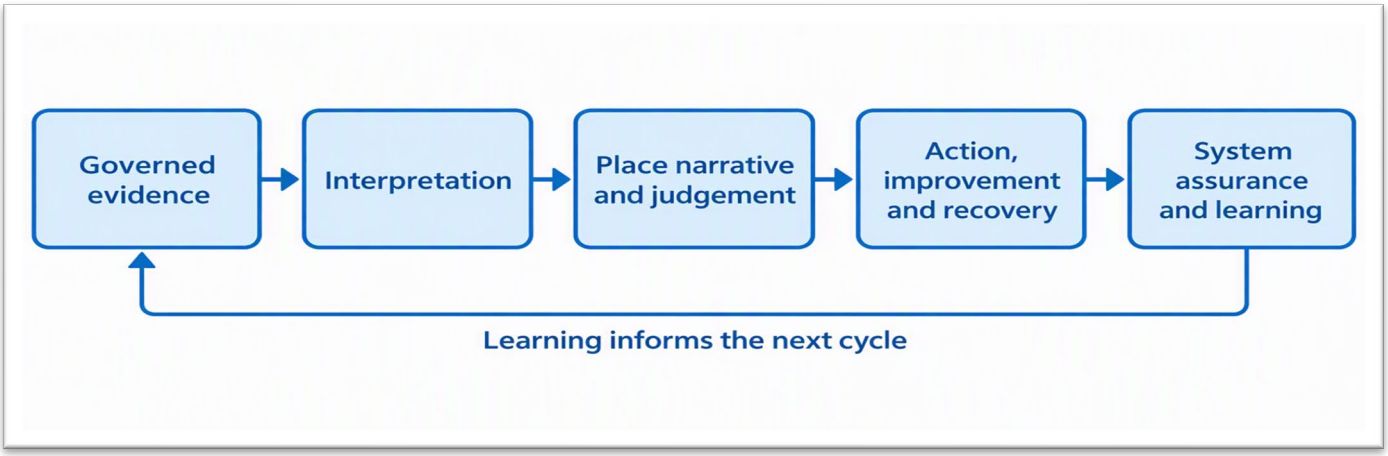
3. Place governance, accountability and assurance

The Place Governance, Accountability, Oversight and Assurance Framework establishes a three-layer model for the operation of Place Partnerships:

1. Place Partnership governance: how partners come together, set priorities, exercise agreed authority and oversee delivery.
2. Resources and hosting: how Place resources are transferred, hosted, protected and managed on behalf of the partnership.
3. Accountability, oversight and assurance of outcomes: how partners collectively understand whether agreed outcomes are being delivered, whether improvement remains on track and what action, support or escalation is required.

It is this third element that provides the basis for the future flow of Place outcomes assurance to Strategic Commissioning Committee.

The framework establishes a Place-led assurance cycle which moves from:



The Place Partnership Board is the principal forum for collective accountability and Place assurance. Evidence about outcomes and delivery is brought together and interpreted to develop a rounded Place narrative. The Partnership Board considers this evidence and reaches a collective judgement about progress, delivery confidence, risks, partner contributions and, where necessary, the effectiveness of improvement or recovery action.

Material Place narratives, cross-cutting themes, strategic risks, support requirements and learning then contribute to the Greater Manchester assurance view through Strategic Commissioning Committee and NHS Greater Manchester Board.

Importantly, the intention is not to create an additional dashboard or parallel performance-management process. Instead, the model is designed to draw assurance from a common understanding of outcomes, delivery, risk and recovery, using evidence already considered through Place governance wherever possible.

4. Progress towards implementation

Work is now focused on moving from the agreed framework into the practical arrangements required to make this assurance cycle operational.

Two complementary elements are being developed.

First, an end-to-end operating process is being refined which translates the framework into the practical arrangements required for routine Place monitoring and interpretation, consideration through Place Partnership Boards, improvement and recovery where required, and onward assurance to NHS Greater Manchester. This is intended to provide the basis for the practical operating guidance required to implement the framework.

Second, a Place Outcomes Assurance Statement is being developed to provide a consistent structure through which Places can bring together evidence, intelligence, interpretation and judgement. Its purpose is to move beyond simply presenting performance information and instead provide a rounded narrative about progress against outcomes, areas of concern, delivery confidence and the action being taken in response.

The development work has reinforced the importance of combining governed quantitative evidence with

operational and qualitative intelligence and multidisciplinary interpretation. This will allow Place Partnership Boards to consider not only what is happening, but the implications for delivery and the credibility of the actions being taken in response. This reflects the approach established in the agreed framework.

Supporting outcomes intelligence and reporting arrangements are being developed alongside this, recognising that effective operation of the assurance model depends upon an appropriate and timely underlying evidence base.

5. Next steps and progress reporting to Strategic Commissioning Committee

The next phase of work will focus on testing and refining the proposed arrangements in practice.

The proposed approach is to use Q4 2026/27 to:

- further refine the end-to-end operating process and Place Outcomes Assurance Statement;
- develop the supporting outcomes intelligence and reporting arrangements;
- test how the assurance cycle operates through Place Partnership governance and into NHS Greater Manchester assurance arrangements; and
- use learning from this initial implementation to refine the approach ahead of wider rollout.

The intention is to move to a more mature and routinely operating model from Q1 2027/28, subject to the learning from the initial testing and development of the supporting outcomes intelligence arrangements.

During this implementation period, it is proposed that Strategic Commissioning Committee maintains oversight through:

- a brief monthly update through the SPP AAAA report, covering progress, key dependencies and any issues requiring Committee attention; and
- a substantive update in February 2027, setting out progress from the initial implementation, the refined operating arrangements and readiness for wider implementation from Q1 2027/28.

As the arrangements mature, reporting to the Committee will transition from updates on developing the assurance process to substantive reporting and assurance on delivery of Place outcomes.

Outcomes Framework: Narrative Introduction

This is the Place Outcomes Framework document, a core underpinning component of the Place Health and Care Partnerships (PHCP) document suite as referenced in the overarching slide deck. It sets out the shared outcomes, priorities and measures that partners will collectively work towards at place, providing a consistent framework for aligning activity, resources and decision making to improve population health and reduce inequalities.

Together with the wider Place Mobilisation components, including the Place Partnership Agreement, Place Governance Framework, Place Team arrangements and Place Funding Framework, this framework establishes a clear basis for shared accountability and performance. It supports partners to translate strategic ambition into coordinated delivery, enabling a collective focus on prevention, neighbourhood based care, and sustainable improvement in outcomes for residents.

1. A narrowing of the healthy life expectancy gap between the most and least advantaged communities, alongside a general uplift for all residents, measuring this through locally meaningful indicators of inequality, prevention, and early years development, anchored in what matters to people, such as “I feel supported to live a healthier life where I live.”, and also ensuring the future sustainability of the NHS and support economic growth.

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Reduce inequality		
Live Well/EX1	Live Well	% residents who feel confident in knowing where to go in their local area to access support for everyday needs	Deliver equity of access	Annual Oversight
PH2	ICB Team	Reduce smoking rates for adults: a rate of less than 5% by 2030 compared to the 2023 level of 12.5%	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
LW2	Live Well	Reduce the percentage of adults who are obese	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
PH1	ICB Team	Reduction in gap between lowest and highest IMDs for age of onset of multiple long term conditions (currently 15yr gap in gm)	To address health inequalities	Annual Oversight
OV8	Strategic Commissioning Plan	To improve Healthy Life Expectancy (HLE) (male/female/all) in GM so that it at least matches the NW of England by 2030	To address health inequalities	Annual Oversight
OV9	Strategic Commissioning Plan	To reduce the gap in HLE between most and least advantaged areas in GM in line with a 10-year ambition to at least halve that gap by 2035 (10 Year Health Plan ambition)	To address health inequalities	Annual Oversight
OF2073	NOF 26/27	Deprivation and ethnicity gap in pre-term births	To address health inequalities	Annual Oversight
OF0117	NOF 26/27	Deprivation gap in lipid and hypertension management	To address health inequalities	Annual Oversight
OF2056	NOF 26/27	% of eligible people supported by obesity prevention programmes	To address health inequalities	Annual Oversight
		Children and Young People		
EX5.1	Live Well	% young people who, through #BeeWell schools survey, agree they have hope and feel optimistic about their future.	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
E.A.6	Op Plan	Expand coverage of mental health support teams (MHSTs) in schools and colleges (including teams in training)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric - consistent across place
EH15	Op Plan	Number of women accessing Specialist Community Perinatal Mental Health Services (12-month rolling metric)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric - consistent across place
Chil1	ICB Team	Reduction in dental extractions in children due to dental cavities	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
Chil2	ICB Team	Reduction in high/very high unmet need for children with asthma (beccor)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
Chil3	ICB Team	Reduction in smoking in pregnancy rates	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
LW8	Early Years Foundation Stage	School readiness as measured by the proportion of children achieving a GLD	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
LW2	Live Well	Reduce the percentage of children who are obese	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
Live Well/AD4	Live Well	(a) No. of children re-referred into children’s social care within 12 months (b) No. of children stepped up from Early Help to Social Care*	A successful LW approach will strengthen and enrich existing approaches to early and targeted family help, providing early intervention for families experiencing challenges, helping children thrive within their own homes and reducing the need for intensive social care interventions. Measures reflect success in	Delivery Metric - consistent across place
		Cancer		
OF0009	NHSOF	Percentage of all cancers diagnosed that are diagnosed at stage 1 or 2	Improve health outcomes for people with cancer through early diagnosis and treatment	Delivery Metric -
Can1	ICB Team	Cancer Screening rates	Improve health outcomes for people with cancer through early diagnosis and treatment	Delivery Metric -
		Long Term Conditions		
LiveWell/AD2	Live Well	% patients with long-term conditions repeatedly not taking up offers of support who are then identified and helped (“Missingness” positively addressed)	Improve health outcomes for people long term conditions - Initial phases focused of cardio-vascular disease, diabetes and respiratory conditions. Scope for wider expansion to a range of other long-term	Delivery Metric - consistent across place
OF0054	NHSOF	Percentage of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Improve health outcomes for people with CVD through improved diagnosis and treatment	Delivery Metric - consistent across place
OF0053	NHSOF	Percentage of hypertension patients treated to target	Improve health outcomes for people with hypertension through improved diagnosis and treatment	Delivery Metric - consistent across place
LD/SMI1	ICB Team	Increasing the proportion of people with Learning Disabilities (aged 14 and over) who receive an annual health check and personalised care plan	Improve health outcomes for people with Learning Disabilities through improved access to annual health checks and personalised care plans	Delivery Metric - consistent across place
SMI1	ICB Team	Increasing the proportion of people with SMI (aged 18 and over) who receive an annual health check and personalised care plan	Improve health outcomes for people with SMI through improved access to annual health checks and personalised care plans	Delivery Metric - consistent across place
		Imms		
Imms2	ICB Team	Childhood vaccinations	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric -
Imms3	ICB Team	Winter illness vaccination rates	Improve health outcomes by prioritising individuals who benefit from vaccination as a key cohort	Delivery Metric -

2. Increased proportion of care delivered in neighbourhood settings, reducing health inequalities, reliance on emergency services and enabling earlier support.

National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
	Access to General Practice		
Live Well	% residents who say it is easy to contact their GP practice (GP Patient Survey)	Improve access to general practice so people can see their GP in a timely, high-quality way	Delivery Metric - consistent across place
National Neighbourhood Framework	90% of clinically urgent patients on the same day by March 2027	Improve access to general practice so people can see their GP in a timely, high-quality way	Delivery Metric - consistent across place
	CHC		
NHSOF	Percentage of continuing healthcare referrals completed in 28 days	Better co-ordination of care for high-priority cohorts	Delivery Metric - consistent across place
	Children and Young People		
National Neighbourhood Framework	Reduce acute outpatient appointments for children under the age of 16 by 10%	Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care	Delivery Metric - consistent across place
National Neighbourhood Framework	Reduction of community waits for children, as part of delivering Medium Term Planning Framework success measures	Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care	Delivery Metric - consistent across place
	Community		
National Neighbourhood Framework / NHSOF	For those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge	Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of discharge delay	Delivery Metric - consistent across place
National Neighbourhood Framework	The proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)	Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of discharge delay	Delivery Metric - consistent across place
Op Plan	Increased utilisation of Pharmacy First, Hypertension Case Finding, Contraception services	Better access in community and reduce reliance on others services	Delivery Metric - consistent across place
Op Plan	Reduction of community waits for adults, as part of delivering Medium Term Planning Framework success measures	Better access in community	Delivery Metric - consistent across place
	Elective		
ICB Team	A&G: deliver a 10% increase in requests for Advice & Guidance over 25/26 baseline in 2026/27	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
ICB Team	Community: work with elective programme and local trust to design and implement a local community / Tier 2 provision for ENT and Gynaecology specialties in 2026/27 [Suggested Change to expand scope and longevity - Work with Elective programme and Trust to implement community/Tier 2 provision through 2026/27]	Deliver more follow-up outpatient care in neighbourhoods	Delivery Metric - consistent across place
ICB Team	Referral rates: reduce referrals by 5% across 10 specialties in 2026/27 vs 2025/26 baseline, in line with BeCCoR EQIS scheme	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
National Neighbourhood Framework	Follow-up appointments: work with local Trust to redesign outpatient model to support reduction in follow-up appointments by at least 10% by March 2027	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
	End of Life		
National Neighbourhood Framework	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing by increasing the number of people identified as approaching end of life by 10%	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing	Delivery Metric - consistent across place
National Neighbourhood Framework	Reduce non-elective admissions and bed days of one day or over by 10% for the end of life cohort by March 2029	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing	Delivery Metric - consistent across place
	Harm		
ICB Team	Reduction in medicines related harm through neighbourhood approaches	Improve safety of care	Delivery Metric - consistent across place
	Long Term Conditions		
National Neighbourhood Framework	Improvement of at least 10% in evidence-based clinical outcomes, measured through quality and outcomes framework standards for CVD, diabetes, COPD, mental health conditions and dementia	Better diagnosis and treatment for people with long-term conditions	Delivery Metric - consistent across place
ICB Team	Reduction in those with high/very high unmet need (CVD, Diabetes, Asthma, COPD) through neighbourhood approaches (beccor)	Improve health outcomes for people with long term conditions	Delivery Metric - consistent across place
NHSOF / National	Percentage of diabetes patients to receive all eight care processes	Better diagnosis and treatment for people with long-term conditions	Delivery Metric - consistent across place
Op Plan	Reducing the number of admissions to inpatient settings and reducing length of stay for people with learning disability and/or autism	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
NHSOF	Percentage change in the number of inpatients who are autistic or have a learning disability	Improving lives of those with LD and/or autism	Delivery Metric - consistent across place
Op Plan	Reduce admission rates to mental health hospitals for people with a learning disability and autistic people	Improving lives of those with LD and/or autism	Delivery Metric - consistent across place
	Mental Health		
SCGCSINAWG	Average LOS (physical and mental health) to be improved	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
ICB Team	Reducing the number of people presenting to A&E in mental health crisis (all age)	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place

ICB Team	Reduction in CRFD for adults, older adults and rehab patients in MH inpatient settings	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
	UEC		
National Neighbourhood Framework	Reduce category 3 and 4 ambulance conveyances in high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life) by March 2029	Have fewer ambulance call-outs for the least urgent cases, with appropriate diversion to relevant urgent care provision in the community.	Delivery Metric - consistent across place
National Neighbourhood Framework	Reduce non-elective admissions and bed days of one day or over by 10% for people with mild to severe frailty, in a care home or housebound by March 2029	Help people with mid to severe frailty, in a care home or housebound, to stay healthier, manage escalating conditions and maintain greater independence for longer.	Delivery Metric - consistent across place
National Neighbourhood Framework	Keep growth flat and work towards an overall reduction in non-elective admissions for high priority cohorts	Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making	Delivery Metric - consistent across place
National Neighbourhood Framework	Contribute to an overall reduction in type 1 ED attendances for high priority cohorts	Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making	Delivery Metric - consistent across place
	Live Well infrastructure		
Live Well	% of neighbourhoods in each locality with a Live Well access point (Centres and Spaces) % LW centres offering: I. Employment support pathway II. Housing support and advice **III. Mental health & wellbeing support** **IV. Primary care** V. Debt advice & income support*	The ambition through LW is for residents to be able to access support in their local area, with “priority offers” available through their local access points. The metric reflects the five proposed priority offers at the time of writing	GMS Implementation monitoring

3. Improved staff wellbeing and retention across sectors, as a marker of a compassionate, sustainable and inclusive local system.

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Workforce		
Live Well/WOW 3	Live Well	% of frontline workers in Live Well roles reporting feeling fully integrated into the wider health, care and other public services in their area	Improve staff satisfaction	Delivery Metric - consistent across place
OF0082	NHSOF	Staff sickness rate	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Delivery Metric - consistent across place
OF0061	NHSOF	Staff survey – raising concerns sub-score	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Delivery Metric - consistent across
OF0084	NHSOF	Staff survey engagement theme score	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Annual Oversight
Ref TBC	NHSOF	Staff survey - We are compassionate and inclusive headline metric score	Improve staff satisfaction, wellbeing and retention drawn from across the entire partnership from several inputs to provide the most accurate	Annual Oversight
Ref TBC	WRES	WRES indicator 5 - %staff experiencing harrassment, bullying or abuse from patients/relatives/public	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	WRES	WRES indicator 6 - %staff experiencing harrassment, bullying or abuse from colleagues, managers	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	WRES	WRES indicator 8 - %staff experiencing discrimination at work from managers, team leaders, colleagues	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	NHSOF	Staff mix - agency spend as % of total temporary staffing/ Bank vs agency spend split	Improve staff retention	

4. More effective use of local partners' collective resource to achieve shared outcomes; evaluating impact and taking an approach of continuous improvement.

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Experience		
Nat20B	National Neighbourhood Framework	By 2027 95% of people with complex needs will have an agreed care plan	Take a proactive approach, where the patient feels in control of their care	Delivery Metric - consistent across place
OV12	Hospital experience scores to be improved	Hospital experience scores to be improved	Improve patient satisfaction with NHS services	Annual Oversight
Nat10	National Neighbourhood Framework	Improve patient satisfaction with GP access	Improve access to general practice so people can see their GP in a timely, high-quality way	Annual Oversight
ICB Team	Local	Improve shared decision making	Improve satisfaction with NHS services	Annual Oversight
OV13	Strategic Commissioning Plan	Mental Health services experience scores to be improved	Improve patient satisfaction with NHS services	Annual Oversight
		Financial stability and productivity		
ICB Team	ICB Team	Place delivers a level of financial efficiency, which a minimum will be the national efficiency requirement (set annually)	To deliver financial stability	Delivery Metric - consistent across place
ICB Team	ICB Team	Place delivers an improvement in productivity and accessibility for the services within the scope of the Place Fund – specific metrics TBC	To deliver financial stability	Delivery Metric - consistent across place
ICB Team	ICB Team	Place delivers at least a balance position with the funding available via the Place Fund (set annually)	To deliver financial stability	Delivery Metric - consistent across place
ICB Team	ICB Team	Place delivers non-financial savings through demand management initiatives - specific metrics TBC	To deliver financial stability	Delivery Metric - consistent across place
NEW	ICB Team/Place Partnership	Clearly identified opportunities to increase and deliver more through the Place Fund).	Over time, and subject to agreed processes, additional budgets may be aligned into the Place Fund using a consistent GM-wide methodology. This aligns with the Strategic Financial Framework's emphasis on:	Delivery Metric - consistent across place
LW /WOW4	Live Well	Shift to greater community control of funding and participation in decision-making around how public money is spent Share of implementation support funding to VCFSE	A further key pillar of LW is: "a resilient VCFSE ecosystem" – creating the conditions for a resilient and connected VCFSE sector resourced to respond to what matters to people, with community-led approaches at its heart. This metric speaks to the central ambition of LW to promote a shift to greater control of funding.	GMS Delivery Monitoring
		Quality		
IMPR1	ICB Team	Increase in QI capabilities (as evidenced by QI skills question on staff survey)	Embed quality improvement methodology	Annual Oversight

PLACE GOVERNANCE, ACCOUNTABILITY, OVERSIGHT AND ASSURANCE FRAMEWORK

NHS Greater Manchester

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1. Purpose and status

This framework describes the governance, accountability, oversight and assurance arrangements for Greater Manchester Place Health and Care Partnerships (PHCP).

The framework supports place-based delivery while maintaining appropriate accountability for public resources, outcomes, and retained organisational duties. It should be read with the Place Partnership Agreement, Partnership Board Terms of Reference, Place Outcomes Framework, Place Fund, Section 75 arrangements, Place Team and workforce-hosting documents, and relevant partner governance.

The framework does not itself transfer statutory functions or create authority for one partner to direct another outside agreed delegations. Detailed delegations, approval routes, contractual obligations, change control and dispute-resolution arrangements sit in the relevant Place Partnership Agreement, Terms of Reference, Section 75 and hosting agreements.

2. What is being proposed

- A three-layer operating model linking partnership governance, resources and hosting, and assurance on delivery of outcomes together.
- A Place Partnership Agreement as the principal framework for each PHCP, alongside a Place Partnership Board and appropriate delivery of governance.
- Place Teams and the Place Fund deployed on behalf of the PHCP to deliver agreed priorities.
- A Place-led accountability, assurance and improvement approach based on governed evidence, expert interpretation, a shared Place narrative and judgement, accountable action, support or recovery, escalation and de-escalation.
- Retention of each organisation’s statutory, contractual, financial, quality, clinical, professional, safeguarding, employment and regulatory accountabilities.
- A consistent Greater Manchester core with local flexibility in the detailed governance architecture.

3. The three-layer model

Layer 1

Place Health and Care Partnership Governance

How partners come together, set priorities, exercise agreed authority and oversee delivery.

Layer 2

Resources and Hosting

How Place resources are transferred, hosted, protected and managed on behalf of the PHCP.

Layer 3

Accountability, Oversight and Assurance of Outcomes

How collective accountability, Place assurance, improvement, support and system oversight operate.

How the layers connect

The Place Partnership Board sets shared priorities and agrees the deployment of the Place Fund and Place Teams within delegated authority. Delivery governance, Place Teams, services and Neighbourhood arrangements deliver those priorities. Outcomes and intelligence inform the Layer 3 accountability, assurance and improvement cycle, with learning, support and recovery feeding back into priorities and resource deployment. Governance interfaces and retained organisational accountabilities operate in parallel throughout.

4. Common design principles

Place-led: Place governance and routine assurance begin locally through the PHCP.

Collective and reciprocal: partners are accountable for their agreed contribution and may seek assurance, support and constructive challenge from one another, including NHS Greater Manchester.

Local accountability with Greater Manchester visibility: local ownership is retained while material themes, exceptions and learning are visible through agreed system routes.

One governed evidence base, different lenses: forums use consistent definitions and sources, with measures, depth and narrative tailored to their purpose.

Intelligence-led: governed data is interpreted with qualitative intelligence, local context, lived experience and professional judgement.

Action and improvement focused: governance supports decisions, accountable actions, recovery, learning and measurable impact.

Proportionate and streamlined: existing governance and information are used wherever possible and additional mechanisms are created only where they add value.

Distinct responsibilities: PHCP accountability does not replace statutory, organisational, contractual, professional or employment accountability.

Transparent and iterative: decisions, risks, actions and assurance positions are recorded clearly, and the approach evolves with learning and maturity.

Minimum core with local flexibility: All Places meet common expectations but may design wider local arrangements to fit context, capacity and maturity.

LAYER 1

Partnership Governance

5. Layer 1: Partnership governance

At the centre of the model is the Place Partnership Agreement. It establishes the PHCP purpose, membership, outcomes, decision-making arrangements, accountabilities and relationships between partners and with NHS Greater Manchester.

5.1 Minimum governance expectations

Place Partnership Board. Provides collective leadership, strategic direction, stewardship of resources, accountability and assurance for agreed Place outcomes. It exercises decision-making only within agreed delegations and cannot bind a partner outside that authority.

Delivery Board or equivalent. Oversees delivery of agreed priorities, monitors programme and operational performance, and escalates strategic risks, delivery challenges and recovery requirements to the Place Partnership Board.

Health and Wellbeing Board interface. Health and Wellbeing Boards retain their independently established statutory functions. Each PHCP should locally agree and document how its arrangements interface with the Health and Wellbeing Board, including alignment, information exchange, referral and avoidance of duplication.

5.2 Critical governance interfaces

Place Partnerships should maintain clear relationships with relevant statutory boards, committees, and PHCP forums. These interfaces provide routes for information, assurance, referral and escalation without transferring or duplicating retained responsibilities. They may include:

- GP and primary care governance arrangements.
- Safeguarding Children Partnerships and Safeguarding Adults Boards.
- Community Safety Partnerships and Domestic Abuse Partnership Boards.
- Strategic estates arrangements.
- Overview and scrutiny arrangements.
- Special Educational Needs and Disabilities partnership arrangements.
- Partner organisation and provider governance.

- Other statutory or partnership forums relevant to local priorities.

5.3 Minimum assurance and enabling functions

Each PHCP should demonstrate effective arrangements for advice, insight, assurance and operational coordination across:

- Clinical and professional leadership.
- Primary care and GP governance.
- Quality and safety.
- Finance and value.
- Performance and risk.
- Neighbourhood delivery.
- Workforce.
- Digital.
- Data, insight and intelligence.
- Estates.

These functions may be provided through existing organisational forums, integrated partnership arrangements, dedicated groups, or other locally agreed mechanisms. Places are not required to establish identical structures but must explain how assurance is obtained; relevant matters reach the Place Partnership Board, and duplication is avoided. The documented arrangements must distinguish clearly between: responsibilities retained by NHS Greater Manchester; responsibilities exercised collectively through the PHCP; and responsibilities retained by individual partner organisations.

NHS Greater Manchester participates as a full partner within Place while also retaining its distinct statutory role as strategic commissioner. In that capacity, it contributes to shared priorities and collective accountability and provides the leadership, governance, expertise and assurance required for the functions it retains, including primary care and GP governance, estates, quality, clinical and professional assurance, finance and commissioning. Participation in the PHCP does not transfer those retained responsibilities to the Place Team or to other partners.

Before responsibilities are assigned or changed, partners must confirm the accountable organisation, decision authority, delivery resource, enabling support, funding and assurance route. The proposed arrangements must be deliverable within available Place capacity. Place

should not be expected to absorb additional functions without explicit partner agreement and commensurate resource, expertise and support.

5.4 Clinical, quality and safeguarding role of Place

Place Health and Care Partnerships provide the forum through which partners collectively consider the contribution of quality, clinical effectiveness, safeguarding and professional leadership to shared Place outcomes; identify and escalate concerns; convene collective discussion; and share learning and effective practice. NHS Greater Manchester remains responsible for the statutory, commissioning, primary care, quality and clinical assurance functions that it retains, and should make the relevant expertise and governance routes available to Place. Individual partners remain responsible for their own statutory, clinical, professional, safeguarding, contractual, and regulatory duties. Collective consideration through Place does not transfer or dilute those retained accountabilities.

5.5 Local flexibility and governance review

Beyond the minimum requirements, Places retain discretion to design governance arrangements reflecting local priorities, partnerships, capacity, and maturity. Each Place should periodically review governance below the Place Partnership Board to determine which enabling and thematic forums remain required, can be combined or streamlined, or should be stood down. The review should test whether the model is deliverable with the capacity and capability available across the PHCP, including whether partners have provided the support required for functions expected to operate through Place. It should also examine recent examples of activity progressed outside Place, assess whether this weakened alignment or accountability, and agree any changes needed to governance interfaces, engagement or escalation routes.

LAYER 2

Resources and Hosting Arrangements

6. Layer 2: resources and hosting arrangements

Layer 2 describes the linked arrangements for the Place Fund, Section 75 agreements, and the Place Delivery and Integration Service. Together, these provide the resources and workforce capacity needed to deliver Place priorities while retaining the statutory, financial, employment and contractual responsibilities of the relevant organisations.

Detailed legal and operational requirements sit within the relevant Section 75 agreement, Place Service and Hosting Contract, service specification and supporting schedules. These arrangements do not create a separate legal entity, transfer statutory functions or allow one partner to direct another outside formally agreed authority.

6.1 Place Fund

For 2026/27, the Place Fund comprises the agreed Better Care Fund services administered jointly by NHS Greater Manchester and the relevant local authority through existing Section 75 arrangements. It is not a separately delegated budget. Wider-aligned expenditure may inform the overall Place financial position but does not automatically form part of the Fund.

The Place Fund operates in shadow form during 2026/27 while governance and assurance arrangements are developed. The PHCP shapes priorities and recommendations, but formal decisions are taken by those holding the relevant lawful authority. Any expansion of the Fund is supported by clear scope, funding, governance, risk allocation, and partner approval.

6.2 Section 75 arrangements

The Section 75 agreement remains the legally operative mechanism through which NHS Greater Manchester and the relevant local authority pool or align agreed resources. It sets out the services and contributions in scope, accountable bodies, decision rights, financial controls, reporting, risk allocation, audit, dispute resolution, and termination arrangements.

Existing Section 75 agreements continue for 2026/27 and, for 2027/28 onwards, are reviewed to reflect the PHCP model, including updated decision rights, oversight and escalation arrangements. Place governance supports collective stewardship but does not replace the lawful authority or approvals of the statutory parties.

6.3 Place Delivery and Integration Service (Place Team)

The Place Delivery and Integration Service provides dedicated capacity to support the PHCP, Neighbourhood arrangements and agreed programmes of work. It coordinates delivery, integration, improvement, performance, risk and assurance and supports collaboration between partners.

The hosted service forms part of the wider multidisciplinary Place Team. Place governance sets its priorities and oversees delivery, while colleagues employed by other partners remain accountable to their substantive organisations unless a separate lawful employment arrangement is agreed.

6.4 Service hosting and employment arrangements (Place Team)

The model is for an NHS Trust or NHS Foundation Trust to host the Place Delivery and Integration Service (Place Team) through a standalone contract with NHS Greater Manchester. NHS Greater Manchester remains the commissioner and funder, while the host becomes the substantive employer and provides the necessary workforce, infrastructure and corporate support.

The hosted workforce and funded establishment remain dedicated to Place and must not be redirected towards unrelated host priorities. The host retains its legal and employer duties, while Place governance retains strategic oversight within agreed decision rights. Any workforce transfer or material change follows applicable employment law, formal consultation, agreed governance and contractual change control.

The Place Service and Hosting Contract specify the funded establishment, contract price, workforce costs, infrastructure requirements, payment arrangements and treatment of vacancies, pay awards, liabilities and service changes.

6.5 Risk, liability and accountability

Risk should sit with the organisation best placed and authorised to manage it. The host remains responsible for employer and operational risks within its control; NHS Greater Manchester retains its commissioning responsibilities; Section 75 parties retain the risks allocated through the agreement; and individual partners retain their statutory, contractual and regulatory duties.

6.6 Assurance, change and dispute resolution

The Place Partnership Board provides strategic oversight of the hosted service and collective oversight of resources deployed on behalf of Place. NHS Greater Manchester retains

contractual oversight, while the host provides assurance on its employment, operational and corporate responsibilities.

6.7 Relationship between partnership and legal documents

Document	Principal purpose	Status / relationship
Place Partnership Agreement	PHCP purpose, governance, ways of working and decision architecture.	PHCP documents contain detailed dispute resolution and amendment provisions.
Partnership Board Terms of Reference	Membership, delegated authority, quorum, decisions and reserved matters.	Operates with the Partnership Agreement.
Section 75 / Place Fund arrangements	Lawful pooling, hosting, transactions, financial controls and approvals.	Legally operative subject to execution and approvals.
Hosted-services contract	Service specification, funding, employer responsibilities, workforce governance, and protections.	Legally operative as specified in executed agreements.
This framework	Common architecture, principles, roles and assurance model.	Does not itself transfer functions or replace operative agreements.

LAYER 3

Accountability, Oversight and Assurance of Outcomes

7. Layer 3: Accountability, Oversight and Assurance of Outcomes

7.1 Purpose

Layer 3 sets out how PHCP, NHS Greater Manchester and partner organisations obtain assurance regarding delivery of the Place Outcomes Framework, associated Neighbourhood outcomes and agreed strategic priorities.

It provides the mechanism through which partners understand:

- whether agreed outcomes are improving;
- whether delivery remains on track;
- whether partner contributions are effective;
- whether the Place Partnership is operating effectively in coordinating collective action; and
- what improvement, support, recovery or escalation may be required?

Layer 3 is the Place application of the wider NHS Greater Manchester direction of travel for integrated reporting and assurance. It does not create an additional dashboard, performance framework, or parallel reporting process. Different governance forums draw the assurance they require from a common understanding of outcomes, delivery, risk and recovery.

The Place Partnership Board provides the principal forum for collective accountability and Place assurance. NHS Greater Manchester and individual partner organisations use the same evidence, Place narrative and governance discussion to inform their own assurance responsibilities while retaining their statutory, organisational, contractual and professional accountabilities.

7.2 Relationship to the Place Outcomes Framework

The Place Outcomes Framework is the principal organising framework for Layer 3.

The Place Outcomes Framework defines the outcomes that PHCP and partners are collectively seeking to improve. It connects Greater Manchester strategic commissioning intentions, Place priorities and Neighbourhood outcomes and provides the basis against which progress, delivery confidence and partner contributions are considered.

The Place Outcomes Framework provides:

- the agreed outcomes against which Place progress and impact are assessed;
- the structure for connecting Greater Manchester, Place and Neighbourhood outcomes;
- the basis for collective accountability and assurance discussions;
- the starting point for identifying the evidence, intelligence and delivery information required;
- the structure for the Place narrative and assurance judgement; and
- the means through which partners assess whether collective action is improving outcomes for residents and communities.

Layer 3 does not create a separate outcomes or performance framework. It provides the governance, accountability, assurance and improvement approach through which partners interpret, understand and act on the evidence relating to the Place Outcomes Framework.

The relationship can be summarised as:

- The Place Outcomes Framework describes the outcomes the PHCP is seeking to achieve.
- Delivery plans, Neighbourhood plans and partner contributions describe how those outcomes will be achieved.
- Layer 3 describes how partners collectively understand progress, reach an assurance judgement, agree action and respond where delivery is off track.

The evidence used through Layer 3 should therefore include both:

- the agreed measures and indicators within the Place Outcomes Framework; and
- the delivery, operational, qualitative, and Neighbourhood intelligence needed to explain the outcome position and support effective action.

7.3 What Layer 3 assures

Layer 3 provides assurance regarding:

- Progress against the outcomes and ambitions set out in the Place Outcomes Framework.
- Delivery of associated Place and Neighbourhood priorities.
- Progress against delivery plans, improvement actions, and recovery trajectories.
- The contribution made by partners towards agreed outcomes.
- The effectiveness of the PHCP in coordinating delivery and collective action.
- The effective stewardship of shared resources.
- Inequalities and Neighbourhood variation, where these affect the interpretation of outcomes or delivery.

- Risks, dependencies, and barriers that may affect delivery of agreed outcomes.
- The credibility of improvement and recovery arrangements where delivery is off track.

Assurance should consider outcomes and impact for residents and communities, rather than relying solely on activity or high-level indicators.

Partnership risk oversight focuses on risks to delivery of shared Place outcomes. It does not replace organisational oversight of statutory duties, clinical and professional governance, safeguarding, operational delivery, finance, quality, contracts, or regulation.

7.4 How accountability, assurance and improvement work

Stage	Lead mechanism	How it works	Output
1. Governed evidence	Data, Insight and Intelligence, relevant reporting domains and partners	Place Outcomes Framework measures, Neighbourhood outcomes measures, delivery information, operational intelligence and qualitative insight are brought together from governed sources. The evidence should include, as appropriate, agreed outcome measures and trajectories; Neighbourhood variation; inequalities; delivery milestones; financial and workforce information; quality and experience; partner contributions; risks and dependencies; recovery progress; and lived experience and professional intelligence.	A consistent and governed evidence base for Place, partner and Greater Manchester use.
2. Interpretation	An appropriate multidisciplinary interpretation process	The evidence is interpreted to understand what has changed; why it has changed; what the change means for delivery of the Place Outcomes Framework; whether inequalities or	A considered draft Place narrative, supported by selected

		Neighbourhood variation affect the assessment; what risks, dependencies or opportunities are present; whether partner contributions remain effective; whether delivery remains credible; and whether improvement or recovery arrangements are likely to achieve the intended outcomes. The process supports constructive challenge but is not an additional governance layer.	measures and evidence.
3. Place narrative and judgement	Place Partnership Board	The Board considers and tests the draft Place narrative and reaches a rounded collective judgement regarding delivery of the Place Outcomes Framework, including the current outcome position, direction and pace of change, delivery confidence, inequalities, risks, partner contributions, PHCP effectiveness, recovery credibility and support required.	A single Place narrative, an agreed collective assurance position and clear decisions.
4. Action, improvement and recovery	Named delivery and executive leads, operating through existing governance routes	The Board agrees accountable owners, the issue being addressed, improvement or recovery action, milestones, support, review points, escalation where necessary and criteria for returning to routine oversight. The relevant operational or executive lead owns any time-bound recovery plan.	Accountable actions, measurable improvement and a clear recovery trajectory.
5. System assurance and learning	Strategic Commissioning Committee and NHS Greater	Material Place narratives, cross-cutting themes, strategic risks, support requirements and learning are consolidated into the Greater	Strategic assurance, system action, escalation

	Manchester Board through the agreed governance route	Manchester view, using the evidence already considered through Place governance wherever possible.	where required and shared learning.

7.5 The Place narrative

The principal shared output of Layer 3 is a concise, decision-focused Place narrative describing progress against the Place Outcomes Framework, the effectiveness of delivery arrangements, the contribution of partners, the level of risk and the actions required to improve outcomes.

The Place narrative is not a single dashboard intended to serve every purpose. It allows different governance forums to understand the same underlying position while applying the lens appropriate to their responsibilities.

The Place narrative should cover:

- the overall assurance assessment and material change since the previous review;
- progress against the Place Outcomes Framework;
- what is improving, what is off track and why;
- inequalities and Neighbourhood variation where these affect interpretation;
- delivery confidence and the effectiveness of delivery arrangements;
- partner contributions and PHCP effectiveness;
- material dependencies and risks;
- agreed actions and accountable owners;
- improvement or recovery milestones and review points;
- support or enabling action required from NHS Greater Manchester or other partners;
- recommendations for deeper review, system action or escalation; and
- learning and effective practice for wider sharing.
    - The Place narrative should be proportionate and focused on matters requiring collective understanding, decision or action. It should draw from information already used through Place and partner governance wherever possible.

7.6 Assurance relationships

The same Place Outcomes Framework evidence, Place narrative and governance discussion support several assurance relationships without creating separate reporting processes. Assurance is explicitly reciprocal and bi-directional: Place provides assurance, intelligence and challenge to NHS Greater Manchester, and NHS Greater Manchester provides assurance, transparency, support and a clear response to Place. The relationship is not an additional upward reporting route; it is a two-way partnership mechanism for understanding impact, resolving barriers and improving decisions affecting Place outcomes.

Assurance relationship	Purpose
Place Partnership Board to partners	Provides the principal collective judgement on delivery of agreed Place outcomes, shared risks, partner contributions and PHCP effectiveness.
Partners to one another	Provides assurance on agreed contributions, commitments and actions, with reciprocal support, challenge and accountability.
Place to NHS Greater Manchester	Provides assurance on delivery of agreed outcomes, use of delegated resources and contribution to NHS Greater Manchester strategic commissioning intentions; shares local population intelligence, identifies barriers and dependencies, challenges proposals where Place outcomes may be affected, and sets out the support or response required from NHS Greater Manchester.
NHS Greater Manchester to Place	Provides assurance on strategic direction, commissioning intent, retained functions and system actions affecting Place; listens to and consults Place when developing commissioning intentions; demonstrates how local population needs and Place intelligence have informed decisions; responds transparently to Place challenge or assurance; and takes enabling action on barriers or dependencies outside Place control.
Reciprocal response and influence	Requires both parties to record the intelligence or challenge received, the response and action agreed, and how the matter influenced commissioning, delivery or assurance decisions. Where Place advice is not adopted, NHS Greater Manchester or the relevant partner explains the

	rationale and any mitigating action through the agreed governance route.
Individual organisations	Enables each organisation to use the shared evidence and Place narrative within its own governance while retaining responsibility for its statutory, contractual, financial, quality, professional, safeguarding, regulatory and employment duties.

7.7 Assurance positions and proportionate response

Position	Meaning	Typical response
Assured	Delivery is broadly on trajectory against the Place Outcomes Framework. Risks are understood and controlled, partner contributions are effective and PHCP arrangements support delivery.	Continue routine Place Partnership Board oversight, maintain agreed actions and share learning and effective practice.
Partially assured	Material gaps or emerging risks are present, but the causes are understood and a credible improvement or recovery approach is in place.	Agree targeted support, accountable actions and a time-bound review. Use a focused deep dive or peer input to strengthen understanding and recovery.
Not assured	There is material or sustained risk to delivery of the Place Outcomes Framework, risk of harm, unclear accountability, ineffective recovery or unresolved partner contribution.	Agree formal recovery arrangements, increased oversight and escalation through the route relevant to the nature of the issue, with clear review and de-escalation criteria.

The assurance position is a rounded collective judgement. It should be informed by evidence and agreed lines of inquiry but should not be reduced to a rigid numerical score.

It does not replace statutory, contractual, regulatory, quality or performance judgements made through other governance routes.

7.8 Escalation, difference of view and dispute resolution

Where delivery of the Place Outcomes Framework is off track, the relevant operational or executive lead owns a time-bound recovery plan with milestones, support requirements, review arrangements and de-escalation criteria.

The Place Partnership Board normally determines whether collective support, further review or escalation is required. NHS Greater Manchester or another partner may also seek further assurance or action where required to discharge its own statutory, organisational or contractual responsibilities.

Escalation should follow the route appropriate to the nature of the issue. This may include:

- Place delivery or outcome oversight;
- NHS Greater Manchester strategic commissioning governance;
- provider performance or contractual arrangements;
- quality, clinical or safeguarding governance;
- financial governance;
- corporate risk arrangements; or
- the sovereign governance of a partner organisation.

A difference in assurance judgement should be recorded transparently, including the evidence, reasons, action sought and governance route through which the matter will be considered.

Detailed dispute-resolution arrangements are specified in the Place Partnership Agreement and are not repeated in this framework.

7.9 System assurance and wider reporting alignment

The Place Partnership Board provides the principal local assurance conclusion regarding delivery of the Place Outcomes Framework.

Material Place narratives, cross-cutting themes and significant exceptions are consolidated for the Strategic Commissioning Committee and, through the agreed route, the NHS Greater Manchester Board.

Where a Place delivery risk meets organisational risk criteria, it is considered through the relevant corporate risk route. Where an issue relates to a retained statutory, quality, safeguarding, contractual, financial or regulatory accountability, it is also considered through the relevant existing governance route.

Layer 3 aligns with the wider NHS Greater Manchester direction of travel towards:

- one governed evidence base, with different views for different responsibilities;
- a shared narrative connecting outcomes, delivery, risk and recovery;
- clear ownership of interpretation, actions and improvement;
- information produced once and reused through existing governance wherever possible; and
- governance discussions focused on understanding, decision-making and improvement rather than debating competing data or producing reports as an end in themselves.

The objective is not to create an additional reporting product. It is to provide a consistent accountability, management and assurance approach through which PHCP, partners and NHS Greater Manchester understand progress against the Place Outcomes Framework, agree action and improve outcomes for residents and communities.

ACCOUNTABILITY SCHEDULE

High-level Responsibilities, Decision-making and Assurance

8. High-level accountability, decision-making and assurance schedule

This schedule describes the framework position. It is not a detailed delegation instrument and does not override formal organisational approvals or operative agreements. Detailed authority, delegations, approval routes, change control and dispute resolution are specified in the Place Partnership Agreement, Terms of Reference, Section 75 and hosting arrangements.

Area	NHS Greater Manchester	Place Partnership Board	Place Lead / Place leadership	Delivery governance	Partner and host organisations
Shared outcomes	Sets or agrees relevant GM strategic commissioning signals and draws assurance through agreed routes.	Owns collective oversight and the Place assurance judgement for agreed outcomes.	Coordinates priorities, delivery and the shared narrative; connects Place and GM.	Maintains delivery grip, actions, dependencies and recovery.	Agree and deliver contributions; retain accountability for own functions.
Decision-making	Retains statutory ICB decisions and acts through formal delegation	Makes or recommends decisions only within delegated authority and	Exercises documented Place Lead and delegated authority	Makes operational decisions within agreed remit and escalates	Take sovereign decisions and approvals required by law or internal

Area	NHS Greater Manchester	Place Partnership Board	Place Lead / Place leadership	Delivery governance	Partner and host organisations
	where agreed.	Terms of Reference.	cannot bind a partner outside it.	reserved matters.	governance.
Place Fund	Provides NHS resources to the pooled or aligned fund through s75 with the relevant local authority	Takes responsibilities formerly held by Locality Board Committees for prioritisation, decision making and oversight of the S75.	Supports implementation and stewardship; identifies risks and formal approvals required.	Monitors delivery and resource use.	Local authority host and partners discharge Section 75, finance and contribution responsibilities.
Place Team / hosted service	Commissioner and funder as set out in the hosted service contract.	Provides strategic oversight of the hosted service on behalf of the PHCP.	Provides strategic and functional leadership, priorities and performance oversight within agreed rights.	Coordinates day-to-day delivery through the Place Partnership Director or equivalent.	Host remains employer and provides lawful employment, infrastructure and corporate assurance; partners contribute agreed capacity.
Quality, clinical	Retains its duties and	Considers implications for	Ensures clinical and	Monitors delivery	Providers, local

Area	NHS Greater Manchester	Place Partnership Board	Place Lead / Place leadership	Delivery governance	Partner and host organisations
leadership and safeguarding	provides system quality and clinical routes.	outcomes, convenes discussion, identifies concerns and shares learning.	professional advice informs Place decisions and concerns reach the correct route.	impacts and actions within remit.	authorities, regional and other bodies retain statutory, professional and safeguarding accountabilities.
Assurance	Receives and responds to Place assurance, intelligence and challenge; provides reciprocal assurance, support and enabling action; explains how Place input has informed decisions;	Owns the collective Place assurance position; seeks assurance and action from NHS Greater Manchester and partners where decisions, retained functions or dependencies affect Place outcomes.	Coordinates evidence, narrative, action and links to GM routes.	Supplies delivery evidence and monitors actions.	Provide accurate evidence, assurance on contributions and use shared intelligence in own governance.

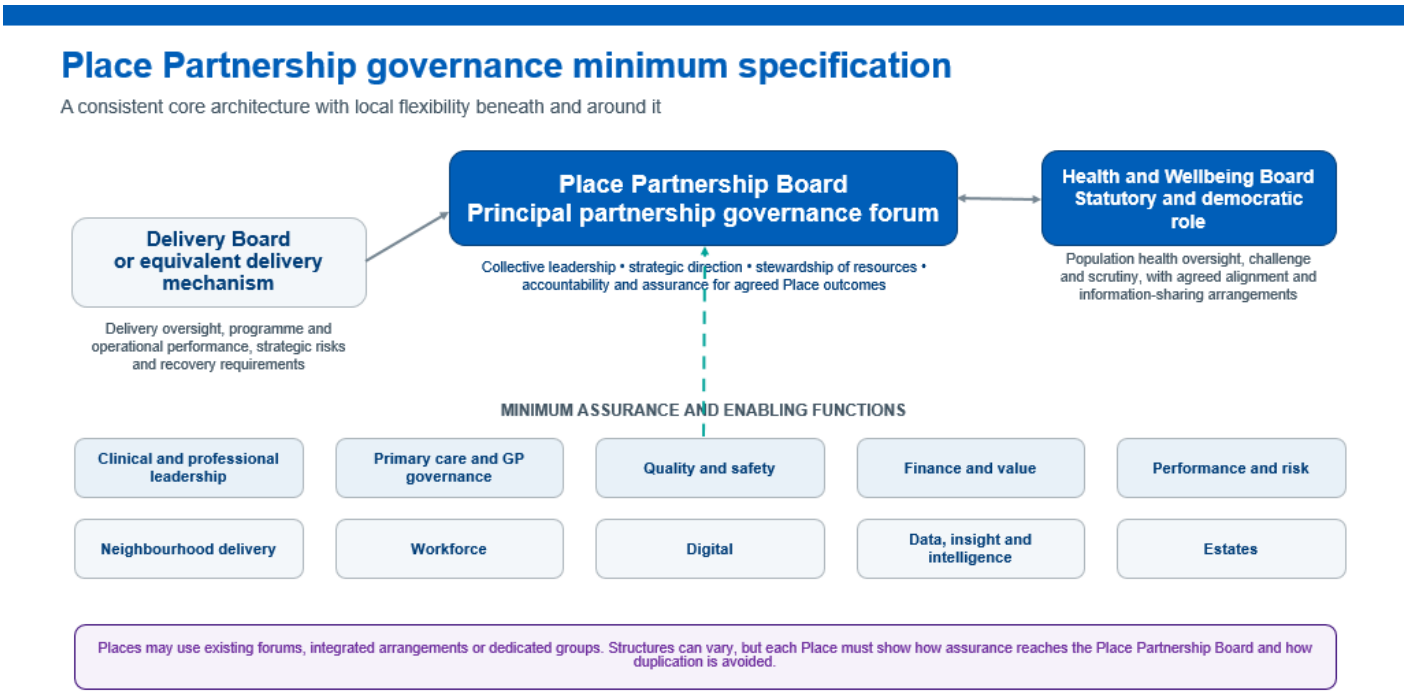
Area	NHS Greater Manchester	Place Partnership Board	Place Lead / Place leadership	Delivery governance	Partner and host organisations
	and consolidates material themes.				
Recovery and escalation	Provides support, enabling action or intervention where within authority or required by retained duty.	Agrees collective support, recovery and escalation position.	Coordinates recovery and makes barriers visible.	Named leads deliver recovery plan and report progress.	Deliver assigned actions and use retained performance, contractual, statutory or risk routes as applicable.
Governance interfaces	Sets relevant GM governance and system assurance routes; engages and consults Place on commissioning intentions and decisions affecting local outcomes;	Determine Place specific governance outside of minimum specification. Maintains appropriate connections without replacing statutory bodies.	Supports alignment, referral and information flow.	Maintains operational links to thematic and Neighbourhood arrangements.	Maintain own governance and statutory partnerships; agree local interfaces.

Area	NHS Greater Manchester	Place Partnership Board	Place Lead / Place leadership	Delivery governance	Partner and host organisations
	and provides clear feedback on the response to Place intelligence and challenge.				
Primary care, GP governance and estates	Retains and discharges relevant statutory and commissioning responsibilities, provides access to expertise and governance routes, and assures Place on decisions and actions affecting local delivery.	Considers the implications for shared outcomes, provides local intelligence and challenge, and agrees collective priorities or recommendations within delegated authority.	Connects NHS Greater Manchester, Place and partner routes; ensures responsibilities, support and escalation are explicit.	Coordinates agreed delivery activity and escalates issues outside its remit or capacity.	Retain their own legal, operational, professional and estates responsibilities and contribute agreed expertise, capacity, and assurance.

PLACE-SPECIFIC GOVERNANCE MAP

Minimum Specification

9. Place Health and Care Partnership governance minimum specification

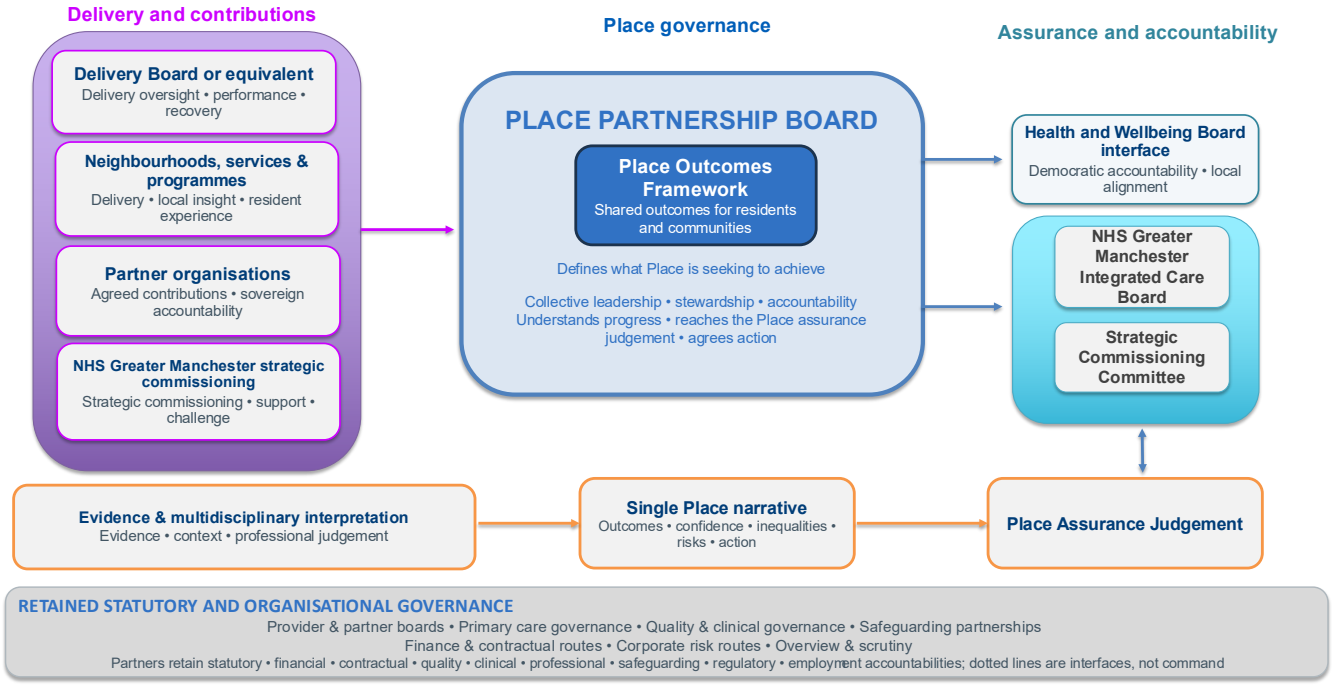


PLACE AND SYSTEM GOVERNANCE MAP

How governance, accountability and assurance connect

10. Governance, accountability and assurance connector map

How Place governance, accountability and assurance connect



NHS
Greater Manchester

Population Health Transformation

4 November 2026

Part of Greater Manchester Integrated Care Partnership

NHS
Greater Manchester

Strategic Commissioning Committee

4 November 2026

Report information.

Required information.	Details.
Title of report.	Population Health Transformation
Author.	David Boulger - Associate Director of Population Health
Presented by.	Charlotte Bailey – Chief Officer for Strategy, People and Partnerships
Contact for further information.	David Boulger - Associate Director of Population Health david.boulger@nhs.net
Executive summary.	This report updates the Strategic Commissioning Committee on the progress made in implementing the Population Health Transformation Programme and seeks endorsement to advance the proposals to the Integrated Care Board for formal governance approval.
The benefits that the population of Greater Manchester will experience.	The transformation proposals aim to establish a more effective and efficient approach to the delivery of pan-GM prevention and population health programmes which will increase the impact of these activities on health outcomes and health inequalities.
How health inequalities will be reduced in Greater Manchester's communities.	The transformation proposals aim to establish a more effective and efficient approach to the delivery of pan-GM prevention and population health programmes which will increase the impact of these activities on health outcomes and health inequalities.

The decision to be made and/or input sought.	Strategic Commissioning Committee are asked to: • Endorse these proposals to progress to the Integrated Care Board on 18/11/26 for formal governance approval.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This proposal primarily supports the delivery of the NHS GM 5 Year Strategic Commissioning Plan priority to "take targeted action on population health and prevention". This proposal primarily mitigates BAF Risk 1: "Failure to deliver prevention-led population health improvement and reduce inequalities"
Key milestones.	NHS GM Chief Officers: 14/10/26 **(Approved)** People and Resources Committee (for FSOD approval): 28/10/26 Strategic Commissioning Committee (for endorsement): 4/11/26 Integrated Care Board (for Approval): 18/11/26 S75 Start Date: 1/4/2027

Leadership and governance arrangements.	The change programme has been overseen by a Transformation Programme Board co-chaired by the ICB Transition Director. The SRO for this transformation programme is the NHS GM Chief Officer for Strategy, People and Partnerships. NHS GM Chief Officer approval for these proposals was given on 14/10/26. The governance responsibility for Population Health sits with the Strategic Commissioning Committee who will have responsibility for overseeing the s75 agreement on behalf of the GM Integrated Care Board. The Population Health and Neighbourhoods Subgroup will ensure delivery it is fully aligned to Live Well, Neighbourhood Health and Place Partnership arrangements. Financial Scheme of Delegation approval sits with the People and Resources Committee who approved the proposals on 28/10/26.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	This transformation programme has been under development for over 12 months and has been subject to extensive system engagement, including an independent review commissioned by the GMPHN which engaged a wide range of system partners. NHS GM Chief Officers, and key colleagues within NHS GM, have received several updates in relation to this transformation programme. The Transformation Programme Board and the underpinning task and finish workstreams have had the direct involvement of NHS GM staff from Corporate Governance, Finance, People Services, Clinical Directorate, and Strategy, People and Partnerships Directorate who have also all reviewed the proposed s75 Agreement.

Financial or Legal Implications	This transformation involves: • NHS GM financial contributions of almost £39million over 5 years. • NHS GM entering a s75 Legal Agreement with Manchester City Council. • Existing NHS GM Staff transferring out of the organisational by way of secondment.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of interest	Report accessibility	EHIA
No	Yes	No	Yes	Yes	No	Yes	No

1. Introduction

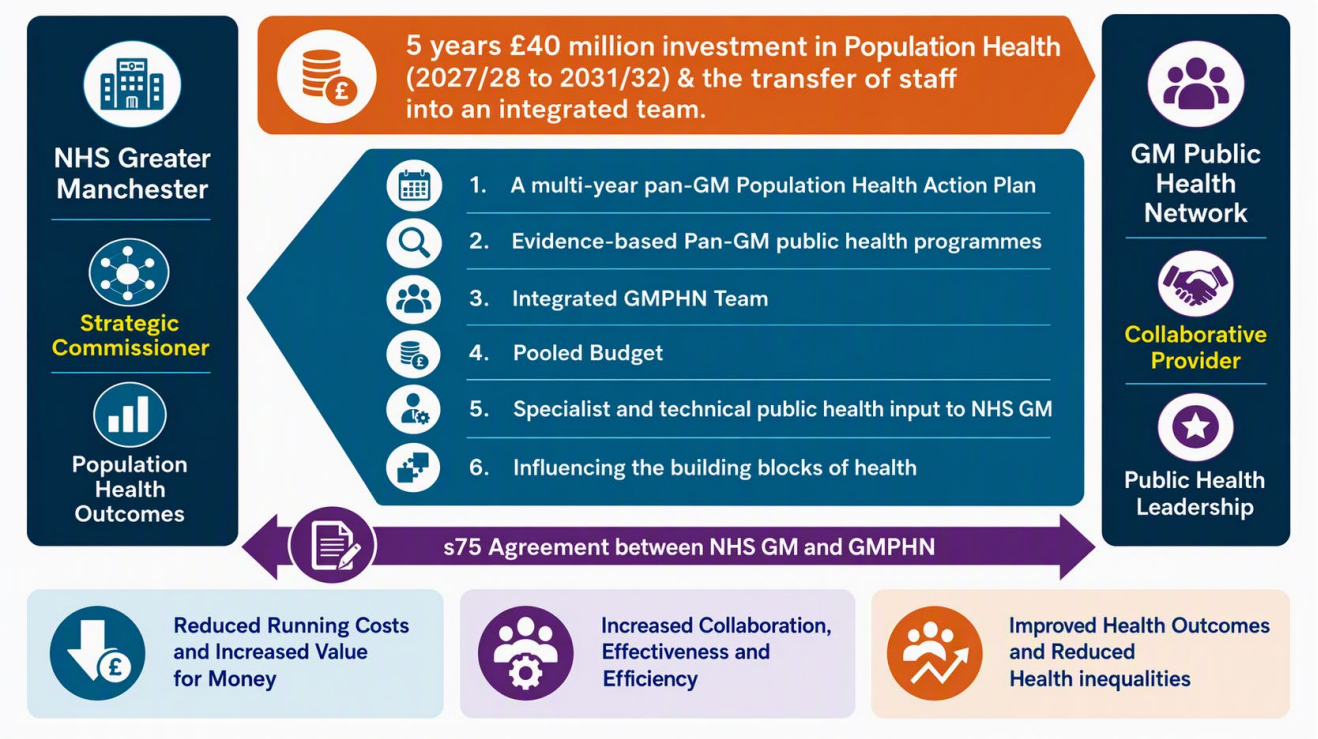
1.1 In the context of the wider Organisational Change programme, work has been ongoing to transform the NHS GM Population Health Function. At the heart of this transformation is a proposal to delegate the delivery of the Population Health improvement programmes and activities that have previously been undertaken internally by the NHS GM Population Health function, to the Greater Manchester Public Health Network (GPMHN), under the distributed leadership of the ten Local Authority Directors of Public Health.

1.2 This shift will be underpinned by the secondment out of the staff employed within the NHS GM Population Health function and the allocation of a proportion of the existing recurrent Population Health budget to the GMPHN.

1.3 Under this arrangement, the GMPHN will discharge several functions which were previously undertaken internally by the NHS GM Population Health function, as well as establishing new activities which will support the ICB in discharging its role as a strategic commissioner, effectively meeting its statutory responsibilities and enabling the delivery of neighbourhood health and Live Well.

1.4 The arrangement will be underpinned by a formal legal agreement under s75 of the NHS Act 2006 between NHS GM and Manchester City Council (MCC) on behalf of the GMPHN. The agreement will cover the period 1st April 2027 to 31st March 2032.

1.5 A summary overview of the proposal is set out below:



1.6 The ongoing implementation of the proposals has been overseen by a Transformation Programme Board, co-chaired by the NHS GM Transition Director and the Chair of the

GMPHN, overall SRO leadership has been provided by the Chief Officer for Strategy, People and Partnerships, and governance oversight has been provided by the Strategic Commissioning Committee.

1.7 Whilst no statutory ICB accountabilities will be transferred under this arrangement, the ICB is delegating a number of functional responsibilities to the GMPHN to undertake on their behalf. The delivery of these functional responsibilities by the GMPHN of behalf of NHS GM, will support the ICB to effectively, visibly and demonstrably discharge its statutory duties in relation to public health and population health.

1.8 It is expected that the transformation will have several beneficial outcomes including:

- Increase system integration and a strengthening of relationships between the NHS and Local Government.
- Improving health outcomes and reducing health inequalities through the scaling up of evidence-based and insight-informed targeted population health interventions aligned to priorities set out in the s75 agreement.
- Reducing ICB expenditure through immediate recurrent savings and the reduction in future demand and cost through an improvement in health outcomes.
- Enhanced provision of technical and specialist public health advice and guidance from GMPHN to the ICB.
- Increased effectiveness, efficiency and value for money achieved through unprecedented levels of integration and co-operation.
- Enhanced collaboration between the NHS and Local Government in relation to data, intelligence, analytics and research

1.9 The proposals have been subject to extensive due diligence, were approved by NHS GM Chief Officers on 14/10/26 and are scheduled for approval by People and Resources Committee (for the purpose of compliance with the Financial Scheme of Delegation) on 28/10/26.

2 Section 75 Agreement

2.1 A Section 75 Agreement for the period 1st April 2027 to 31st March 2032 has been co-produced by NHS GM, MCC and GMPHN (**Appendix 1**) and has been subject to legal due diligence, on behalf of NHS GM, by Hill Dickenson Solicitors.

2.2 The Section 75 Agreement has been approved by Chief Officers (14/10/26), and, subject to endorsement from Strategic Commissioning Committee, will progress to the Integrated Care Board for approval on 18/11/26.

2.3 The Section 75 Agreement will then be progressed through MCC governance with approval by the MCC Executive expected in December 2026.

2.4 The key points to draw out from the s75 Agreement are as follows:

- The background section sets out the context, parameters and overarching expectations of the agreement.
- S2 confirms the term of the Agreement as 1/4/2027 to 31/3/2032
- S3 sets out the general principles underpinning the agreement
- S4-8 set out the core functionalities required to enable the agreement to work in practice.
- S9 confirms the NHS GM financial contribution of £7.8million per year from 2027/28 to 3031/32.
- S10 confirms that the architecture to underpin future staffing arrangements will be via a separate secondment agreement.
- S11 confirms the treatment of overspend and underspend, including the safeguards in place to mitigate overspends, and the general principles underpinning decisions around underspends.
- S18 describes the overarching governance including a GMPHN Directors of Public Health Group that makes recommendations, a GMPHN s75 Partnership Board (with senior NHS GM and MCC representation) and connectivity into wider ICB and MCC governance arrangements.
- S22 creates a provision for either partner to terminate the agreement subject to providing 6 months' notice.
- Schedule 1 Part 1 sets out the priority deliverables required from the GMPHN under this arrangement. This includes:
    - Providing specialist, technical public health advice and guidance to NHS GM
    - Delivering a range of priority programmes to address key causes of poor health and health service demand / cost
    - Retaining the ability to redeploy staff and resources towards emerging issues, major incidents and emergencies such as a pandemic response.
- Schedule 1 Part 2 provides a summary of the GMPHN Action Plan 2026/27 and Parts 3 and 4 are placeholders for a 4-year GMPHN Action Plan and Investment Strategy for 2027 to 2031 that are under development and scheduled for completion by December 2026.
- Schedule 2 Part A provides a more detailed overview of the governance arrangements described in S18 including specifying membership of the Programme Board for the NHS GM Chief Officer for Strategy, People and Partnerships and Chief Clinical Officer.

- Schedule 3 provides more detail on the finance arrangements referenced in S9 and S11, including a process for the NHS GM Chief Finance Officer and Chief Officer having a decision-making role in relation to any proposed year to year carry forward of underspend.

- Schedule 5 provides a high-level description of the NHS GM and GMPHN staff who are in scope of the future staffing model.

3 Financial Impact

3.1 These proposals generate a recurrent annual saving of £2.1million to the ICB through a combination of existing NHS GM staffing costs being met by GMPHN (£1.3million) and a saving of £800k that has already been applied to the Population Health programme budget from 2026/27 based upon on assumption that the more integrated model would generate efficiencies.

3.2 The ICB commitment to the model is £39million in total over the 5-year period, broken down as £7.8million per annum.

3.3 Non-progression of the proposals will generate a recurrent £2.1million pressure within the ICB budget.

3.4 The proposals will lead to the creation of an aligned budget with the annual contributions from Local Authorities to GMPHN also flowing into MCC from 1/4/27 to create a pooled budget, under the day-to-day management of the NHS GM Associate Director of Population Health / GMPHN Programme Director. This is already in place in shadow form.

3.5 The funding committed under this arrangement is from the existing dedicated Population Health function budget and does not represent the totality of ICB Population Health investment, with the majority of existing funding remaining within the ICB.

4 Staffing Impact

4.1 Following approval by NHS GM Chief Officers on 14/10/26, it is proposed that 17 x NHS GM Population Health Function staff are seconded from NHS GM to Manchester City Council (as the host of the GM Public Health Network) for the duration of the s75 Agreement.

4.2 This will require a period of staff engagement and formal staff consultation, and this will be completed during Q3 2026/27.

4.3 Under the terms of the s75 agreement, GMPHN would meet the entirety of the staffing costs for this cohort of employees (c£1.3million).

4.4 The ICB staff will work as part of an integrated team alongside the existing GMPHN staff under the single leadership of a GMPHN Programme Director – a role that will be fulfilled by the NHS GM Associate Director of Public Health. This integrated structure is already in place in shadow form.

4.5 The s75 Agreement does not cover future staffing arrangements in any detail, with these instead being managed concurrently through a Secondment Agreement.

5 Recommendations

5.1 Strategic Commissioning Committee are asked to:

- Endorse these proposals to progress to the Integrated Care Board on 18/11/26 for formal governance approval.

NHS
Greater Manchester

APPENDIX 1

S75 AGREEMENT

Dated **2026**

THE COUNCIL OF THE CITY OF MANCHESTER

and

NHS GREATER MANCHESTER INTEGRATED CARE BOARD

PARTNERSHIP AGREEMENT PURSUANT TO SECTION 75 NHS ACT 2006 RELATING TO THE GREATER MANCHESTER PUBLIC HEALTH NETWORK

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THIS AGREEMENT is made on day of 2026

PARTIES

(1) **MANCHESTER CITY COUNCIL** of Town Hall, Albert Square, Manchester M60 2LA ("**Council"**); and

(2) **NHS GREATER MANCHESTER INTEGRATED CARE BOARD of** Tootal Buildings, 56 Oxford Street, Manchester, M1 6EU (the "**NHS GM"**),

each a "**Partner**" and together the "**Partners**".

BACKGROUND

(A) Greater Manchester has a lengthy track record of working collaboratively across organisations and places to improve the health of the population and tackle health inequalities and is recognised nationally and internationally as an exemplar. This strong existing platform has created an opportunity to go further and to establish an unprecedented level of collaboration and integration within which the 10 Local Authority Directors of Public Health, acting together through the GM Public Health Network and hosted by the Council, will take on delegated responsibility for the exercise of a number of functional activities currently undertaken by the Population Health team employed by NHS Greater Manchester. This transformational shift will be underpinned by the integration of the NHS GM Population Health function staff and existing GMPHN staff into a single team, with access to a multi-year investment of almost £40 million from NHS GM and the existing GMPHN funding streams and overseen through the collective system leadership of the GMPHN and the Local Authority Directors of Public Health who make up its membership.

(B) The Greater Manchester Public Health Network (the "**GMPHN**") is a collaborative network bringing together the Directors of Public Health of the 10 Greater Manchester Councils to undertake joint pan-GM activity aimed at improving health outcomes and reducing health inequalities across the entire Greater Manchester area (https://www.gmphn.com/). The GMPHN is overseen by the **GMPHN Directors of Public Health Group**, and hosted by the Council. Terms of reference and membership of the GMPHN Directors of Public Health Group as at the date of this Agreement are attached at Schedule 2, Part B.

(C) NHS GM has the responsibility for commissioning health services pursuant to the 2006 Act across the entire Greater Manchester area (the "**GM Area**"). In meeting this responsibility, NHS GM directly commissions a number of prevention and population health programmes that are discharged through a Population Health function. In delivering these, NHS GM collaborates with the GMPHN who also commission programmes and services (the "**GMPHN Programmes**"). As at the date of this Agreement the GMPHN led programmes are commissioned and delivered by a team who are employees of Tameside Council (the "**GMPHN Team**"). Through this transformation programme, both sets of staff will work together as a joint team. Further information regarding workforce arrangements as at the Commencement Date is set out in Schedule 5.

(D) The Council is one of the 10 Greater Manchester Councils which together with Bolton Council, Bury Council, Oldham Council, Rochdale Council, Salford City Council, Stockport Council, Tameside Council, Trafford Council and Wigan Council form the Constituent Councils of the Greater Manchester Combined Authority (the "**GM LAs**"). Each of the 10 GM LAs has responsibility for commissioning and/or providing social care services and public health services on behalf of the population of their own GM LA area. This agreement does not replace those local responsibilities and instead provides additionality to them.

(E) NHS GM wishes to make arrangements to delegate responsibility for the commissioning and delivery of the prevention and population health activities and programmes that are currently led by the NHS GM Population Health function to the "**GMPHN**" through the Council as the host (the "**GMPHN Host LA**") on behalf of all of the 10 GM LAs, the GMPHN and NHS GM). The Council has agreed with NHS GM, the GMPHN Directors of Public Health Group and the other

9 GM Local Authorities that the Council will act as the GMPHN Host LA during the period from 1 April 2027 to 31 March 2032.

(F) Under this arrangement, the GMPHN will deliver against the following key delegated responsibilities which have been discharged to date by the NHS GM Population Health function:

- Develop and implement an action plan to prevent some of the key causes of poor health and health inequalities in Greater Manchester.
- Lead, commission, implement and evaluate programmes to achieve the ambitions set out in the action plan.
- Oversee a joint team of staff made up from the current NHS GM Population Health function and existing GMPHN staff employed by Tameside Council and cover the pay costs of the NHS GM staff deployed to work on the delivery of the plan.
- Manage a pooled set of financial resources aligned to the priorities set out in the action plan
- Provide expert, specialist and technical public health advice and guidance to NHS GM to enable NHS GM to meet its statutory duties and achieve its strategic ambitions with a specific focus on healthcare, public health, health protection / outbreak management, strategic commissioning, safeguarding people and organisational 'left shift'.

As at the date of this Agreement the "**Key Deliverables**" for the collaborative work programme are set out at Schedule 1 to this Agreement.

(G) Section 75 of the 2006 Act gives powers to local authorities and integrated care boards to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(H) The purpose of this Agreement is to set out the terms on which the GMPHN Directors of Public Health Group, NHS GM and the Council as GMPHN Host LA will collaborate and establish a framework through which the GMPHN Directors of Public Health Group, NHS GM and the Council as GMPHN Host LA can secure the future commissioning and delivery of the NHS GM prevention and population health programmes which are the subject of this Agreement through lead commissioning arrangements, and through which NHS GM and the Council as GMPHN Host LA will pool funds for the commissioning and delivery of the programmes as set out in this Agreement.

(I) The aims and benefits of the Partners in entering into this Agreement are to:

a) benefit the population of the entire GM area by improving the quality and efficiency of the commissioning and delivery of prevention and population health programmes that are joint priorities of the GMPHN and NHS GM;

b) make more effective use of resources through the establishment and maintenance of a pooled fund (the "**GMPHN Pooled Fund**"), hosted by the Council, for revenue expenditure on the GMPHN Programmes; and

c) ensure that all 10 GM LAs are involved in decisions regarding the "**GMPHN Plan", "Annual GMPHN Pooled Budget Plan"** and the delivery of a shared work programme.

(J) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act, to the extent that exercise of these powers is required for the Partners to comply with their obligations under this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

2027-2031 Financial Years GMPHN Pooled Fund Plan means the financial plan which will be adopted by the GMPHN Directors of Public Health Group for each of the 2027-28, 2028-29, 2029-30, 2030-31 and 2031-32 Financial Years, setting out the agreed high-level strategic priorities for Greater Manchester Public Health for these five Financial Years, and the main GMPHN Programmes which will be funded through the GMPHN Pooled Budget for these five Financial Years. Once the 2027-32 Financial Years GMPHN Pooled Fund Plan has been agreed by the GMPHN Directors of Public Health Group it will be inserted at Schedule 1, Part 4 of this Agreement.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

Annual Pooled Fund Plan means the plan which will be produced by the GMPHN Directors of Public Health Group in Q4 of each Financial Year of this Agreement setting out planned expenditure for the following Financial Year.

Annual Report means the annual report produced by the Greater Manchester Public Health Network in accordance with Clause 20 (Review).

Approved Expenditure means any expenditure approved by the Partners in writing or as set out in the Annual Pooled Fund Plan in relation to a GMPHN Programme Contract over and above any Contract Price, Permitted Expenditure or agreed Third Party Costs.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the Commencement Date.

Commencement Date means 00:01 hrs on 1 April 2027.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of any GM LA, or the interests of a Service User; or

(c) which is a trade secret.

Contract Price means any sum payable under a GMPHN Programme Contract as consideration for the provision of goods, equipment or services as required as part of the

GMPHN Programme and which, for the avoidance of doubt, does not include any Default Liability.

Data Protection Legislation means all applicable data protection and privacy legislation in force from time to time in the UK including the UK GDPR, the Data Protection Act 2018 and the Privacy and Electronic Communications (EC Directive) Regulations 2003 and any guidance and codes of practice issues by any Regulatory or Supervisory Body from time to time.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a GMPHN Programme Contract to be payable by any Partner(s) as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under a GMPHN Programme Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant GMPHN Programme Contract, liable to the Provider.

End Date means 23:59 hrs on 31 March 2032.

Financial Contributions means the financial contributions made by the Partners to the GMPHN Pooled Fund in any Financial Year in accordance with Clause 9.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies; or

(g) any form of contamination or virus outbreak,

in each case where such event is beyond the reasonable control of the Partner claiming relief.

Functions means the NHS Functions and the Health- Related Functions

GM Area means the entire Greater Manchester Area covered by the 10 GM LAs.

GM LAs means the Council and each of Bolton Council, Bury Council, Oldham Council, Rochdale Council, Salford City Council, Stockport Council, Tameside Council, Trafford Council and Wigan Council.

Greater Manchester Public Health Network (GMPHN) means the collaborative network bringing together the 10 GM LA Directors of Public Health to undertake joint pan-GM activity aimed at improving health outcomes and reducing health inequalities (https://www.gmphn.com/) across the entire GM Area.

GMPHN Action Plan means the plan agreed by the Directors of Public Health group as the means of discharging the responsibilities set out in this Agreement.

GMPHN Directors of Public Health Group means the group which oversees the GMPHN. Terms of reference for the GMPHN Directors of Public Health Group as at the date of this Agreement are attached at Schedule 2, Part B.

GMPHN Host LA means the Council.

GMPHN Pooled Fund means the GMPHN pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations.

GMPHN Pooled Fund Manager means such officer of the Host Partner which includes a Section 115 Officer for the GMPHN Pooled Fund as nominated by the Host Partner from time to time to manage the GMPHN Pooled Fund in accordance with Clause 8.

GMPHN Programme Contract Specification means a specification setting out the arrangements for an individual GMPHN Programme Contract recommended by the GMPHN in the 5 year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32 and commissioned by the Council (acting as the Host Partner of the GMPHN Pooled Fund) under this Agreement.

GMPHN Programme Contract means an agreement entered into by the Council in exercise of its obligations under this Agreement to secure the provision of a GMPHN Programme in accordance with the Annual Pooled Fund Plan.

GMPHN Programme(s) means any prevention, health and social care programmes and services that are agreed by the GMPHN and intended to benefit the population of the entire GM area (including preventative services) or a specified population within GM as recommended by the GMPHN in the 5 year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32, and commissioned and delivered by the Council under the arrangements set out in this Agreement and more specifically defined in each GMPHN Programme Contract Specification.

GMPHN Team means those employees of NHS GM and Tameside Council who are engaged in the commissioning and delivery of the GMPHN Programmes at the Commencement Date and who will remain employees of NHS GM and Tameside Council following the coming into force of this Agreement on the Commencement Date. From the Commencement Date, the employees of NHS GM and Tameside Council who form the GMPHN Team will be seconded to the Council. The Council will enter into separate arrangements with Tameside Council in respect of the employees of Tameside Council who are members of the GMPHN Team.

Host Partner means the Council as host of the GMPHN Pooled Fund.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Health-Related Functions means those of the health-related functions of the Council specified in Regulation 6 of the Regulations, as relevant to the commissioning of the GMPHN Programmes.

ICB Statutory Duties means the duties of NHS GM pursuant to Sections 14Z32 to 14Z44 of the 2006 Act.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and

publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which the Council, acting as the Host Partner, commissions and delivers the GMPHN Programme Contracts in relation to individual GMPHN Programmes which are detailed in the Annual GMPHN Pooled Fund Plan.

Lead Partner means the Council, acting as Host Partner, which is responsible for commissioning and delivering an individual GMPHN Programme Contract under a GMPHN Programme Contract Specification as detailed in the Annual GMPHN Pooled Fund Plan.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the NHS GM as are relevant to the commissioning of the GMPHN Programmes.

Non-Recurrent Payments means funding provided by a Partner to the GMPHN Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 9.4.

Overspend means any expenditure from the GMPHN Pooled Fund in a Financial Year which exceeds the aggregate value of the Financial Contributions for that Financial Year.

Partner means each of NHS GM and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board means the Partnership Board responsible for oversight of this Agreement and the operation of the GMPHN Pooled Fund as set out in Clause 18 and Schedule 2 or such other governance arrangements as the Partners agree. In the refreshed GMPHN governance arrangements, the function of the Partnership Board will be carried out through the GM System Assurance Group.

Partnership Board Quarterly Reports means the reports that the GMPHN Pooled Fund Manager shall produce and provide to the Partnership Board on a Quarterly basis.

Permitted Budget means in relation to a GMPHN Programme where the Council is the Provider, the budget that the Partners have set in relation to a particular GMPHN Programme.

Permitted Expenditure has the meaning given in Clause 7.4.

Personal Data has the meaning given to it in the Data Protection Legislation.

Provider means a provider of any GMPHN Programmes commissioned and delivered under the arrangements set out in this Agreement including the Council where the Council is a provider of any GMPHN Programmes.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended from time to time).

Regulatory or Supervisory Body means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Partner must comply or to which it must have regard and includes the Information Commissioner.

Special Category Personal Data means Personal Data that falls within the scope of special categories of Personal Data specified in Article 9 of the UK GDPR.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual GMPHN Programme as the Council reasonably and properly incurs in the proper performance of its obligations under this Agreement and as approved by the Partnership Board.

Underspend means any expenditure from the GMPHN Pooled Fund in a Financial Year which is less than the aggregate value of the Financial Contributions for that Financial Year.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until the End Date or until it is terminated in accordance with Clause 22.

2.3 The duration of each individual GMPHN Programme Contract shall be as set out in the relevant GMPHN Programme Contract or if not set out, for the duration of this Agreement unless terminated earlier by the Partners in accordance with Clause 22.3.

3 GENERAL PRINCIPLES

3.1 The Partners agree that the GMPHN Pooled Fund has been created to enable the Council (acting as the Host Partner) to commission the GMPHN Programmes and activities detailed in the GMPHN Action Plan as approved by the GMPHN Directors of Public Health Group and aimed at meeting the following responsibilities:

- Develop and implement an action plan to prevent some of the key causes of poor health and health inequalities in Greater Manchester
- Lead, commission, implement and evaluate programmes to achieve the ambitions set out in the action plan.
- Oversee a joint team of staff made up from the current NHS GM Population Health function and existing GMPHN staff employed by Tameside Council and cover the pay costs of the NHS GM staff deployed to work on the delivery of the plan.
- Manage a pooled set of financial resources aligned to the priorities set out in the action plan.
- Provide expert, specialist and technical public health advice and guidance to NHS GM to enable NHS GM to meet its statutory duties and achieve its strategic ambitions with a specific focus on healthcare public health, health protection / outbreak management, strategic commissioning, safeguarding people and organisational ‘left shift’.

3.2 Nothing in this Agreement shall affect the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations.

3.3 The Partners agree to:

3.3.1 treat each other with respect and an equality of esteem;

3.3.2 be open with information about the performance and financial status of each; and

3.3.3 provide early information and notice about relevant problems.

3.4 For the avoidance of doubt, the aims and outcomes relating to an individual GMPHN Programme Contract will be set out in the relevant GMPHN Programme Contract Specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to commission the GMPHN Programmes detailed in the Annual GMPHN Plan which has been approved by the GMPHN Directors of Public Health Group. This includes the following commissioning mechanisms:

4.1.1 Lead Commissioning Arrangements (with the Council acting as Lead Partner);

4.1.2 the establishment of the GMPHN Pooled Fund,

in relation to individual GMPHN Programme Contracts (the "**Flexibilities**").

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework for the operation of the GMPHN Pooled Fund through which the Partners (acting on the recommendations of the GMPHN Directors of Public Health Group and in accordance with the 5 year GMPHN Action Plan and Investment Plan for 2027/28 to 2031/32, approved by the GMPHN Directors of Public Health Group) can secure the provision of the GMPHN Programmes and activities in accordance with the terms of this Agreement.

5.2 This Agreement shall include such Functions as shall be agreed from time to time by the Partners as are necessary to commission the GMPHN Services in accordance with their obligations under this Agreement.

5.3 Where the GMPHN Directors of Public Health Group wishes to amend the 5-year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32 for any Financial Year, the GMPHN Directors of Public Health Group will inform the Partners as soon as possible, and ensure that there is sufficient money in the GMPHN Pooled Fund for that Financial Year to fund the Council, as Host Partner, to deliver the amended GMPHN Action Plan. Any material amendment to the 5-year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32 which has a financial implication for the GMPHN Pooled Fund or either Partner shall be reviewed by the Partnership Board and approved by the Partners prior to implementation.

5.4 The Council, as the Host Partner, will work with the GMPHN Directors of Public Health Group and NHS GM to try to accommodate any proposed changes to the 5-year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32 (including where the GMPHN Directors of Public Health Group wishes to request that the Council commissions a new individual GMPHN Programme Contract for any Financial Year or terminates an individual GMPHN Programme Contract). For the avoidance of doubt, where the GMPHN Directors of Public Health Group wishes to amend the 5-year GMPHN Action Plan and Investment Plan for 2027/28 to 2031/32 for any Financial Year, the Council, as Host Partner, will not be required to make any financial contribution to the GMPHN Pooled Fund to fund such amendments.

6 COMMISSIONING ARRANGEMENTS

General

6.1 For each Financial Year, the Council, as Host Partner shall seek to commission the GMPHN Programme Contracts as set out in the relevant GMPHN Programme Contract Specification detailed in the 5-year GMPHN Action Plan and Investment Plan for 2027/28 to 2031/32 which has been approved by the GMPHN Directors of Public Health Group.

6.2 To enable this, the GMPHN Directors of Public Health produce an Annual Pooled Fund Plan in Q4 of each Financial Year of this Agreement, setting out planned expenditure for the following Financial Year, to be approved by the Partnership Board.

6.3 Delivery shall be subject to oversight by the Partnership Board.

6.4 The Partners shall comply with all relevant legal duties, and guidance applicable to, both Partners in relation to the GMPHN Programmes being commissioned.

6.5 Each Partner shall keep the other Partner and the Partnership Board and the GMPHN Director of Public Health Group regularly informed of the effectiveness of this Agreement, and any Overspend or Underspend in the GMPHN Pooled Fund.

6.6 Where there are Lead Commissioning Arrangements in respect of an individual GMPHN Programme then prior to any new GMPHN Programme Contract being entered into the Partners (taking into account the recommendations of the GMPHN Directors of Public Health Group) shall agree in writing:

6.6.1 how the liability under each GMPHN Programme Contract shall be apportioned in the event of termination of the relevant individual GMPHN Programme; and

6.6.2 whether the GMPHN Programme Contract should give rights to third parties.

Appointment of Council as Lead Partner

6.7 Where there are Lead Commissioning Arrangements in respect of an individual GMPHN Programme the Council as Lead Partner shall:

6.7.1 endeavour to ensure that the individual GMPHN Programmes are funded within the parameters of the Financial Contributions of NHS GM in relation to each particular GMPHN Programme in each Financial Year;

6.7.2 commission GMPHN Programme Contracts in accordance with the relevant GMPHN Programme Contract Specification as detailed in the 5-year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32 – the "**2027-2032 Financial Years GMPHN Pooled Fund Plan**" (as relevant) as approved by the GMPHN Directors of Public Health Group;

6.7.3 contract with Provider(s) for the provision of the GMPHN Programme on terms agreed with NHS GM and the GMPHN Directors of Public Health Group (provided that, for the avoidance of doubt NHS GM and the GMPHN acknowledge and agree that the Council will contract with Provider(s) in accordance with the Council's own Constitution and Financial Regulations (including the Council's Contract Procurement Rules));

6.7.4 ensure that performance management and contract monitoring of all GMPHN Programme Contracts is in place, and that appropriate action is being taken where a GMPHN Programme fails to deliver contracted requirements;

6.7.5 make payment of all sums due to a Provider pursuant to the terms of any GMPHN Programme Contract; and

6.7.6 keep the other Partner and the Partnership Board and the GMPHN Directors of Public Health Group regularly informed of the effectiveness of the arrangements including any Overspend or Underspend in the GMPHN Pooled Fund.

7 ESTABLISHMENT OF THE GMPHN POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain the GMPHN Pooled Fund for revenue expenditure as agreed by the Partners.

7.2 At the Commencement Date there shall be a single GMPHN Pooled Fund in respect of this Agreement.

7.3 The GMPHN Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.4 Subject to Clause 7.5, it is agreed that the monies held in the GMPHN Pooled Fund may only be expended on the following:

7.4.1 the Contract Price;

7.4.2 where the Council is to be the Provider, the Permitted Budget;

7.4.3 Third Party Costs where these are set out in the relevant GMPHN Programme Contract Specification or as otherwise agreed in advance in writing by the Partnership Board and the GMPHN Directors of Public Health Group;

7.4.4 the staff costs of the staff employed within the NHS GM Population Health function, (whether seconded to the Council or deployed separately by NHS GM to deliver the GMPHN Programmes and activity within the scope of this Agreement);

7.4.5 Approved Expenditure as set out in the relevant GMPHN Programme Contract Specification or as otherwise agreed in advance in writing by the Partnership Board and the GMPHN Directors of Public Health Group; and

("**Permitted Expenditure**").

7.5 All direct and indirect staff and team costs accrued as part of the collaborative model of working and the delivery of the delegated tasks, will be paid by MCC from the GM Public Health Network budget. This will include pay, estates, ICT and digital equipment and licenses, telephone equipment and use, travel expenses, room bookings, training, and any other associated costs.

7.6 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of the Partnership Board and the GMPHN Directors of Public Health Group.

7.7 For the avoidance of doubt, monies held in the GMPHN Pooled Fund may not be expended on Default Liabilities unless this is agreed by the Partners and the GMPHN Directors of Public Health Group in accordance with Clause 7.5.

7.8 Pursuant to this Agreement, the Partners agree to appoint the Council as Host Partner for the GMPHN Pooled Fund. The Host Partner shall be the Partner responsible for:

7.8.1 holding all monies contributed to the GMPHN Pooled Fund on behalf of itself and NHS GM;

7.8.2 providing the financial administrative systems for the GMPHN Pooled Fund;

7.8.3 appointing the GMPHN Pooled Fund Manager; and

7.8.4 ensuring that the GMPHN Pooled Fund Manager complies with their obligations under this Agreement.

8 GMPHN POOLED FUND MANAGEMENT

8.1 The GMPHN Pooled Fund Manager for the GMPHN Pooled Fund shall have the following duties and responsibilities:

8.1.1 the day-to-day operation and management of the GMPHN Pooled Fund;

8.1.2 ensuring that all expenditure from the GMPHN Pooled Fund is in accordance with the provisions of this Agreement and the relevant GMPHN Programme Contract Specification;

8.1.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the GMPHN Programmes and the GMPHN Pooled Fund;

8.1.4 ensuring that full and proper records for accounting purposes are kept in respect of the GMPHN Pooled Fund;

8.1.5 reporting to the GMPHN Directors of Public Health Group and the Partnership Board as required by this Agreement and by the Partnership Board and the GMPHN Directors of Public Health Group;

8.1.6 ensuring action is taken to manage any projected under or overspends relating to the GMPHN Pooled Fund in accordance with this Agreement;

8.1.7 preparing and submitting to the Partnership Board and the GMPHN Directors of Public Health Group Quarterly Reports (or more frequent reports if required by the Partnership Board and/or the GMPHN Directors of Public Health Group) and an annual return about the income and expenditure from the GMPHN Pooled Fund together with such other information as may be required by the Partners and the Partnership Board and/or the GMPHN Directors of Public Health Group to monitor the effectiveness of the GMPHN Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the GMPHN Pooled Fund Manager in time for the reporting requirements to be met.

8.2 In carrying out their responsibilities as provided under Clause 8.1, the GMPHN Pooled Fund Manager shall:

8.2.1 have regard to the recommendations of the Partnership Board and the GMPHN Directors of Public Health Group; and

8.2.2 be accountable to the Partners for delivery of those responsibilities.

8.3 The GMPHN Directors of Public Health Group may request the Partnership Board to agree to amend the allocation of the GMPHN Pooled Fund between individual GMPHN Programmes. Any such amendments shall require approval of the Partnership Board.

9 FINANCIAL CONTRIBUTIONS

9.1 The NHS GM contribution to the GMPHN Pooled Fund will cover any GMPHN Programme expenditure, and the staffing costs of NHS GM staff seconded to the Council, or deployed to the delivery of the overarching GMPHN Programmes from 1 April 2027 to 31 March 2032 to commission and manage the GMPHN Programme Contracts which are procured by the Council from the GMPHN Pooled Fund.

9.2 The Financial Contribution of NHS GM to the GMPHN Pooled Fund for each Financial Year until the End Date shall be £7,800,000 (seven million and eight hundred thousand pounds).

9.3 Financial Contributions will be paid as set out in Schedule 3.

9.4 With the exception of Clause 12, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the GMPHN Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Partnership Board and GMPHN Directors of Public Health Group minutes and recorded in the budget statement as a separate item.

10 NON-FINANCIAL CONTRIBUTIONS

10.1 Unless set out in a GMPHN Programme Contract Specification or otherwise agreed by the Partners, each Partner shall provide the non-financial contributions for any GMPHN Programme for which they are Lead Partner, or as required in order to comply with its obligations under this Agreement in respect of the commissioning of a particular GMPHN Programme.

10.2 Each GMPHN Programme Contract Specification shall set out non-financial contributions of each Partner including staff (including the GMPHN Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of GMPHN Programme Contracts and the GMPHN Pooled Fund).

10A STAFFING ARRANGEMENTS

10A.1 NHS GM and the Council will enter into parallel arrangements in relation to the future staffing model, commencing on 1 April 2027, including staff deployment (by secondment or other means) to the Council to commission and manage the GMPHN Programme Contracts which are to be procured by the Council from the GMPHN Pooled Fund.

10A.2 To create an integrated team, the Council will enter into separate arrangements with Tameside Council in relation to the staff employed by Tameside Council on behalf of GMPHN.

10A.3 A description of the existing workforce arrangements (made up of existing staff from NHS GM and Tameside Council) anticipated as at the Commencement Date is set out in Schedule 5 (Workforce Arrangements).

10A.4 For the avoidance of doubt, Schedule 5 is intended to be descriptive only and does not create employment obligations or confer employment rights between any Partner and any individual.

11 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

11.1 The Partners have agreed risk share arrangements as set out in Schedule 3, which provide for risk share arrangements arising within the commissioning of services from the GMPHN Pooled Fund.

Overspends in GMPHN Pooled Fund

11.2 Subject to Clause 11.3, the Council, as Host Partner for the GMPHN Pooled Fund, shall manage expenditure from the GMPHN Pooled Fund within the Financial Contributions and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

11.3 The Council as Host Partner for the GMPHN Pooled Fund shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that it has used reasonable endeavours to ensure that the only expenditure from the GMPHN Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board and the GMPHN Directors of Public Health Group in accordance with Clause 11.4.

11.4 If the GMPHN Pooled Fund Manager identifies an actual or projected Overspend the GMPHN Pooled Fund Manager must ensure that the Partnership Board and the GMPHN Directors of Public Health Group is informed as soon as reasonably possible and the provisions of the relevant GMPHN Programme Contract Specification and Schedule 3 shall apply.

11.5 If an actual or projected Overspend is identified, including an Overspend projected to exist at the End Date the GMPHN Pooled Fund Manager shall escalate it to the Partnership Board as soon as reasonably possible. The Council shall not be responsible for funding or otherwise making good any Overspend. The Partnership Board must put in place arrangements to make good the Overspend, which may include reducing, or top-slicing, funding available in a subsequent Financial Year and/or the early termination or reduction of GMPHN Programmes.

Underspend

11.6 In the event that expenditure from the GMPHN Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, or where the expenditure in relation to an individual GMPHN Programme is less than the agreed allocation to that particular individual GMPHN Programme, the resulting Underspend shall be separately identified and accounted for from the Council's overall financial position. The Partners shall consult with the GMPHN Directors of Public Health Group to develop proposals for potential carry forward to the next Financial Year, and Schedule 3 shall apply. Any use of an Underspend carried forward from a previous Financial Year shall be subject to prior consultation with, and agreement of, the GMPHN Directors of Public Health Group. Where the carry forward of all or part of an Underspend is not agreed, the amount not approved for carry forward shall be refunded to the Partners in proportion to their respective Financial Contributions to the GMPHN Pooled Fund for the Financial Year in which the Underspend arose. Any such proposals, use and repayment shall be subject to the Law and the standing orders and standing financial instructions (or equivalent) of the Partners.

11.7 When assessing requests to carry forward underspend across financial years, consideration should be given to the general principles underpinning the NHS GM commitment to this collaboration including the recognition that this is part of a 5 year investment totalling £39,000,000 (thirty-nine million pounds), and that there is an assumption that carry forward is acceptable if there is demonstrable evidence that it can be utilised in a way which improves health outcomes and reduces health inequalities.

12 CAPITAL EXPENDITURE

12.1 The GMPHN Pooled Fund shall not normally be applied towards any one-off capital expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners.

12.2 Any request from the Council to NHS GM to advance capital expenditure would require formal approval of the GMPHN Directors of Public Health Group and the Partnership Board.

13 VAT

The Partners shall agree the treatment of the GMPHN Pooled Fund and individual programme areas of expenditure for VAT purposes in accordance with any relevant guidance from HM Revenue and Customs.

14 AUDIT AND RIGHT OF ACCESS

14.1 The Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the GMPHN Pooled Fund in accordance with the Regulations and the Local Audit and Accountability Act 2014.

14.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee or member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

15 LIABILITIES AND INSURANCE AND INDEMNITY

15.1 Subject to Clause 15.2, and 15.3, if a Partner (the "Indemnified Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual GMPHN Programme) as a consequence of any act or omission of another Partner (the "Indemnifying Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or any GMPHN Programme Contract then the Indemnifying Partner shall be liable to the Indemnified Partner for that Loss and shall indemnify the First Partner accordingly.

15.2 Clause 15.1 shall only apply to the extent that the acts or omissions of the Indemnifying Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Indemnifying Partner acting in accordance with the instructions or requests of the Indemnified Partner or the Partnership Board.

15.3 If any third party makes a claim or intimates an intention to make a claim against either Partner which may reasonably be considered as likely to give rise to liability under this Clause 15, the Indemnified Partner will:

15.3.1 as soon as reasonably practicable give written notice of that matter to the Indemnifying Partner specifying in reasonable detail the nature of the relevant claim;

15.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Indemnifying Partner (such consent not to be unreasonably conditioned, withheld or delayed); and

15.3.3 give the Indemnifying Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

15.4 Each Partner shall ensure that they maintain policies of insurance in respect of all potential liabilities arising from this Agreement and in the event of Losses shall seek to recover such Loss through the relevant policy of insurance.

15.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one Partner is entitled to bring a claim against the other Partner pursuant to this Agreement.

Conduct of Claims

15.6 In respect of the indemnities given in this Clause 15:

15.6.1 the Indemnified Partner shall give written notice to the Indemnifying Partner as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

15.6.2 the Indemnifying Partner shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the Indemnified Partner, the Indemnifying Partner shall consult with the Indemnified Partner about the conduct and/or settlement of such claims and proceedings and shall at all times keep the Indemnified Partner informed of all material matters; and

15.6.3 the Partners shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

16 STANDARDS OF CONDUCT AND SERVICE

16.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective standing orders and standing financial instructions).

16.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's

obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

16.3 NHS GM is subject to the ICB Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the GMPHN Pooled Fund are therefore subject to ensuring compliance with the ICB Statutory Duties and clinical governance obligations.

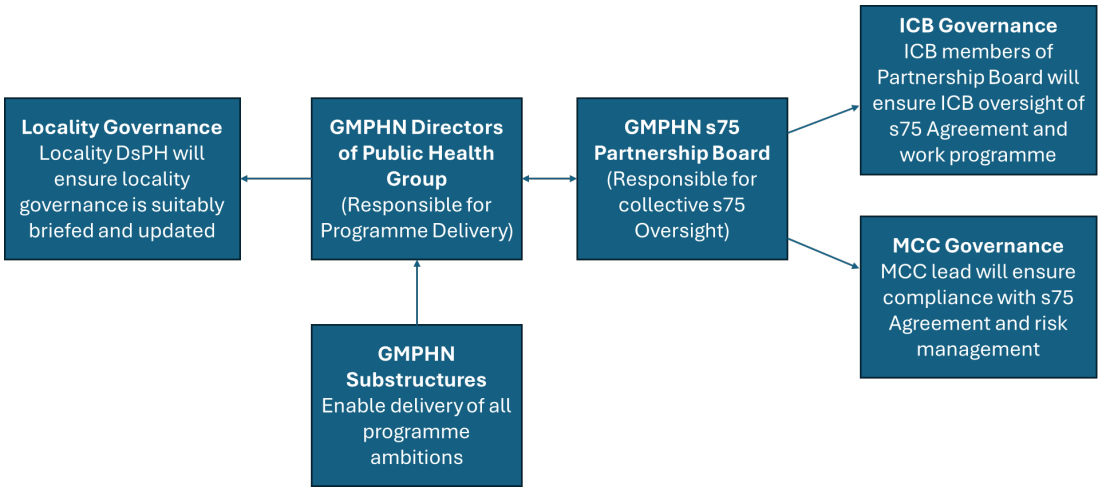
16.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the GMPHN Programme.

17 CONFLICTS OF INTEREST

17.1 The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 4.

18 GOVERNANCE

18.1 An outline summary of the governance arrangement is as follows:



18.2 Overall strategic oversight of partnership working between the Partners is provided by the Partnership Board, taking account of the recommendations and strategic leadership provided by the GM Directors of Public Health Group.

18.3 The Partners have established a Partnership Board to oversee the joint delivery of the GMPHN Programmes and the operation of this Agreement.

18.4 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 18 and Schedule 2, Part A.

18.5 The terms of reference of the Partnership Board shall be as set out in Schedule 2, Part A as may be amended or varied by written agreed from time to time.

18.6 The GMPHN has established the GMPHN Directors of Public Health Group to provide collective GMPHN leadership and management of the delivery of the GMPHN Programmes.

18.5 The terms of reference of the GMPHN Directors of Public Health Group shall be as set out in Schedule 2, Part B and may be amended or varied by written agreed from time to time.

18.6 NHS GM will routinely oversee and review GMPHN Programme delivery from an organisational perspective through formal system governance. This will initially be through a Population Health and Neighbourhood Group, reporting into a Strategic Commissioning Committee, which in turn reports to the Integrated Care Board.

18.7 Each individual GM Local Authority who forms part of GMPHN will be responsible for ensure that their local Health and Wellbeing Board is routinely updated (at least annually) on the GMPHN work programme.

18.8 Each individual GMPHN Programme will have a named lead on behalf of GMPHN and this will be formally reviewed on a bi-annual basis.

18.9 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

18.10 The Partnership Board shall oversee delivery of the individual GMPHN Programmes and financial management of the GMPHN Pooled Fund, taking account of recommendations made by the GMPHN Directors of Public Health Group, as set out in Clause 11 and Schedule 2.

18.11 Each GMPHN Programme Contract Specification shall confirm the governance arrangements in respect of the individual GMPHN Programme and how that individual GMPHN Programme is reported to the Partnership Board and the GMPHN Directors of Public Health Group.

19 ESCALATION OF MATTERS

19.1 Where:

(a) the Partnership Board considers that a proposed decision presents a significant financial, legal, reputational or operational risk to either or both Partners, or to any GMPHN Programme; or

(b) a proposed decision falls outside the individual delegated authority of Partnership Board members;

the matter shall be referred to the NHS GM Board and/or the Council governance for consideration and decision.

19.2 Neither Partner shall be required to approve or implement a proposal which has not been approved in accordance with its governance arrangements.

20 REVIEW

20.1 The Council shall procure that GMPHN produces a Quarterly Report which shall be provided to the GMPHN Directors of Public Health Group and the Partnership Board.

20.2 The Council shall procure that GMPHN undertakes an annual review ("**Annual Review**") of the operation of this Agreement, the GMPHN Pooled Fund and the provision of the GMPHN Programmes within 2 Months of the end of each Financial Year.

20.3 Subject to any variations to this process agreed by the GMPHN Directors of Public Health Group and the Partnership Board, Annual Reviews shall be conducted in good faith.

20.4 The Council shall procure that GPMHN prepares an Annual Report to summarise the findings of the Annual Review and this will be completed within 3 months of the end of each Financial

Year. A copy of the Annual Report shall be provided to the GMPHN Directors of Public Health Group and the Partnership Board.

20.5 The Partners and the individual Local Authorities who form the GMPHN will be responsible for ensuring the Annual Report is taken through necessary organisational governance for information.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the GMPHN Programmes.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by either Partner giving not less than 6 Months' notice in writing to terminate this Agreement, provided that termination shall take effect on the next 31 March falling after expiry of the notice period.

22.2 Each Individual GMPHN Programme may be terminated in accordance with the terms set out in the relevant GMPHN Programme Contract Specification.

22.3 If a Partner ("**Relevant Partner**") fails to meet any of its obligations under this Agreement, the other Partner may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partner may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach.

22.5 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.5.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities (including the GMPHN Pooled Fund) to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to GMPHN beneficiaries, the GMPHN Programmes, the employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.5.2 where the Council has entered into a GMPHN Programme Contract which continues after the termination of this Agreement, NHS GM shall continue to contribute to the Contract Price in accordance with the agreed contribution for that GMPHN Programme prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.5.3 the Council, acting as Lead Partner, shall make reasonable endeavours to amend or terminate a GMPHN Programme Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the GMPHN Programme Contract) where NHS GM requests the same in writing Provided that the Lead Partner shall not be required to make any payments to the Provider for such amendment or termination unless NHS GM shall have agreed in advance that NHS GM shall be responsible for any such payment;

22.5.4 the Partnership Board and the GMPHN Directors of Public Health Group shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.5.5 termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.6 In the event of termination in relation to an individual GMPHN Programme the provisions of Clause 22.5 shall apply in relation to the individual GMPHN Programme (as though references as to this Agreement were to that individual GMPHN Programme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Partners' respective chief executives or nominees with appropriate authority to act and take decisions shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable

by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause 24.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 24, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement;

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25; and

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners agree to exercise their rights and obligations under this Agreement at all times in compliance with their respective obligations under the Data Protection Legislation.

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; or

29.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the Director of Public Health, Dr Cordelle Ofori;

Email: Cordelle.Ofori@manchester.gov.uk

and

29.3.2 if to NHS GM, addressed to the Chief Officer: Strategic People and Partnerships, Charlotte Bailey;

Email: charlotte.bailey37@nhs.net

30 VARIATION

30.1 No variations to this Agreement will be valid unless they are agreed and recorded in writing by the Partnership Board and signed for and on behalf of each of the Partners to the Agreement.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUBCONTRACTING

The Partners shall not sub-contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any transfer to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Agreement pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arise out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

This Agreement has been entered into on the date stated at the beginning of it.

THE COMMON SEAL of
THE COUNCIL OF THE CITY OF MANCHESTER
was hereunto affixed in pursuance of
an Order of the Council of the said City:

……
Authorised Signatory

Executed on behalf of **NHS GREATER MANCHESTER INTEGRATED CARE BOARD**
by two Authorised Signatories:

……
Authorised Signatory

……
Authorised Signatory

SCHEDULE 1

PART 1

GM Public Health Network (GMPHN) s75 Deliverables 2027-2032

This document outlines the key deliverables which will sit with the Greater Manchester Public Health Network, utilising the GMPHN Pooled Budget and resources under the scope of the Section 75 Partnership Agreement.

This is split into three key areas:

- Strategic Leadership & Influence
- Public Health Priority Programmes
- Emerging Risks.

There is a broad scope of system-wide work, enablers and other business as usual, which has not been included in these deliverables, and which will form part of a more comprehensive 5-year GM Public Health Network Plan 2027-2032.

While some of this work will be system-wide across GM, it will be important to have clarity around the roles and responsibilities of the GMPHN, NHS GM and other key stakeholders involved in areas of work. The scope of work will not include meeting the existing and statutory obligations of NHS GM or other organisations within the GM system.

Strategic Leadership & Influence

- Ensuring delivery of the overarching GMPHN Programme aligns and contributing to the delivery of the NHS GM 5-year Strategic Commissioning Plan, particularly the priorities around improving healthy life expectancy, and improving the health of children.

- Providing specialist, technical public health advice and guidance to NHS GM as required including, but not exclusive to, it's role as a strategic commissioner and in satisfying its statutory responsibilities in relation to health inequalities, health protection and health care public health.

- Further shifting the focus of delivery towards prevention across the GM system.

- Working with a range of partners across the GM system to influence work on the wider, social and commercial determinants of health.

Public Health Priority Programmes

To maximise impact across GMPHN Programmes, a small number of priority programmes have been identified to focus the capacity of GMPHN. This is where the bulk of staffing and financial resource will be directed to deliver.

Three priority GMPHN Programme areas have been agreed:

1. Societal Health Harms (Tobacco, Alcohol, Food, Physical Inactivity)
2. Mental Wellbeing
3. Sexual and Reproductive Health (Including HIV)

Emerging Risks

The pooled resources of the Greater Manchester Public Health Network will also have capacity to enable it to respond to new and emerging opportunities, risks and threats in relation to public health.

In exceptional circumstances this could form part of a broader system response in partnership with other agencies to a complex or major incident or event.

Examples could include a GM-wide response to an emerging pandemic situation including flu or a novel infection as was seen with covid-19. In such circumstances, the network would re-prioritise workloads in order to redeploy expertise and resources to tackle these issues as required.

Measuring Impact

The impact of the priority programmes will be demonstrated through a contribution towards improving the following key metrics:

Tobacco

- Reduction in adult smoking prevalence
- Faster reductions in high prevalence groups (routine and manual, deprived and SMI)
- Reduction of smoking at time of delivery
- Increased uptake of smoking/tobacco cessation services
- Increased achievement of 4-week quit rate (including all forms of tobacco use)
- Increase in number of smoke free environments
- Reduction in the proportion of young people self-reporting the use of vapes (Trading Standards NW Young Persons Survey)

Alcohol

- Reduced alcohol-related hospital admissions
- Reduced alcohol-related crime, violence, and anti-social behaviour
- Increased numbers using digital interventions
- Increase numbers accessing and sustaining alcohol treatment and recovery and support (particularly in known risk groups)
- Increase the number of representations made by GM Public Health teams on alcohol licensing applications and reviews
- Increase in the number of people self-reporting that they consume no alcohol / below harmful levels of alcohol
- Reduction in young people identifying as binge drinkers (Trading Standards NW Young Persons Survey)

Food and Health

- Increase proportion of children at healthy weight in year 6 and narrow the gap in unhealthy weight between the most and least disadvantaged areas
- Decrease in food advertising exposure (esp. near schools and on public transport)
- Increase uptake of healthy start vouchers and free school meals
- Increase in the number of case-based examples of effective local policy development to tackle the impact of unhealthy food environments (including supplementary planning policies to restrict unhealthy food availability; aspects of Local Plans which tackle unhealthy food environments; bespoke localised advertising policies restricting the promotion of fast food)

Physical Inactivity

- % of adults who are inactive
- % of adults from the most deprived backgrounds who are active
- % of children and young people who are active for less than 30 minutes a day

Mental Wellbeing

- Decrease percentage of adults with common mental disorder (QOF)
- Increase life satisfaction scores (ONS)
- Increase emotional wellbeing score in children and young people (Bee Well Survey) particularly in known risk groups
- Reduce rate of suicide

Sexual Health

- Reduced under-18 conceptions
- Reduction in the rate of repeat terminations
- Increase in the uptake rate of long-acting reversible contraception (LARC)
- Increased rate of HIV testing (particularly in known risk groups)
- Reduced rate of late HIV diagnosis

PART 3

5-YEAR GMPHN ACTION PLAN FOR THE 2027-28, 2028-29, 2029-30,2030-31 and 2031-32 FINANCIAL YEARS

[*To be inserted once agreed*]

PART 4

2027-2032 FINANCIAL YEARS GMPHN POOLED FUND PLAN

[*To be inserted once agreed*]

SCHEDULE 2– GOVERNANCE

PART A

1 GMPHN s75 PARTNERSHIP BOARD

1.1 The membership of the Partnership Board will be as follows:

1.1.1 NHS GM:

- Chief Officer for Strategy, People and Partnerships
- Chief Clinical Officer

or a deputy to be notified to the Chair in advance of any meeting;

1.1.2 the Council:

- Member representative duly appointed
- Member representative duly appointed

or a deputy to be notified in writing to Chair in advance of any meeting.

[Deputies must be able to contribute and make decisions on behalf of the Partner organisation they are representing.]

1.2 The Partnership Board may agree to invite one or more individuals to attend any meeting or part of a meeting. Such attendees may participate in discussions but may not participate in decision making.

1.3 The Chair of GMPHN and the Programme Director for GMPHN shall attend meetings of the Partnership Board.

2 Role of Partnership Board

3 The Partnership Board shall:

3.1.1 provide strategic oversight of this Agreement and the delivery of the GMPHN Programmes;

3.1.2 oversee the operation of the GMPHN Pooled Fund and receive assurance from the GMPHN Pooled Fund Manager regarding financial performance, programme delivery and risk management;

3.1.3 review Quarterly Reports, Annual Reports and any other reports required under this Agreement;

3.1.4 approve Annual Pooled Fund Plans produced by the GMPHN Directors of Public Health Group;

3.1.5 review actual and forecast expenditure from the GMPHN Pooled Fund and oversee management of any Overspend or Underspend;

3.1.6 review and approve any Overspend mitigation plans prepared pursuant to this Agreement;

3.1.7 oversee delivery of the GMPHN Action Plan and any subsequent amendments to it;

3.1.8 review and make recommendations to the Partners in relation to material variations to this Agreement, Annual Pooled Fund Plans and GMPHN Programmes;

3.1.9 review strategic and operational risks associated with the arrangements and maintain oversight of risk mitigation actions;

3.1.10 consider any matter escalated to it pursuant to this Agreement;

3.1.11 make recommendations to the Partners regarding matters requiring formal approval through each Partner's governance arrangements;

3.1.12 perform such other functions as are assigned to it by this Agreement.

4 Reporting

The Partnership Board shall report directly to each of the GM ICB Board and the Council Executive Partners on a Quarterly and annual basis.

5 Partnership Board Support

The Partnership Board will be supported by officers from the Partners from time to time.

6 Meetings

6.1 The Partnership Board will meet Quarterly at a time to be agreed following receipt of each Quarterly report of the GMPHN Pooled Fund Manager.

6.2 The quorum for meetings of the Partnership Board shall be a minimum of one representative from each of the Partners. Members of the Partnership Board may participate in Partnership Board meetings by telephone or video conference and shall count towards the quorum in doing so.

6.3 The Chair of GMPHN and the GMPHN Programme Director shall be standing attendees of the Partnership Board and shall be entitled to participate in discussions and make recommendations but shall not exercise decision-making rights.

6.4 Decisions of the Partnership Board shall be made by consensus between the Partners. Each member of the Partnership Board shall make the formal decision in accordance with their own internal governance requirements. Where consensus is not reached then the item in question will in the first instance be referred to the next meeting of the Partnership Board. If no consensus is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement.

6.5 Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

6.6 Minutes of all decisions shall be kept and copied to the Authorised Officers within seven (7) days of every meeting.

7 Delegated Authority

7.1 The Partnership Board is authorised within its members' individual limits of delegated authority (which is received through their respective organisation's own financial scheme of delegation) to:

7.1.1 authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of NHS GM to the aggregate contributions of NHS GM to the GMPHN Pooled Fund; and

7.1.2 authorise the Council, acting as Lead Partner, to enter into any GMPHN Programme Contracts necessary for the provision of any GMPHN Programmes.

8 Information and Reports

The GMPHN Pooled Fund Manager shall supply to the Partnership Board on a Quarterly basis the financial and activity information as required under the Agreement.

9 Post-termination

The Partnership Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any GMPHN Programme Contracts are received by the Partners in the same proportions as their respective contributions at that time.

10 Review

These terms of reference will be reviewed on an annual basis by the Partners.

Date of the next review: 1st October 2027

PART B

GMPHN DIRECTORS OF PUBLIC HEALTH GROUP

GM Public Health Network – Directors of Public Health Group
Core Purpose
• To provide overarching collaborative leadership of the GM Public Health Network and all its plans and responsibilities.
Key Responsibilities
1. Ensure a collaborative pan-GM approach to improving population health and tackling health inequalities. 2. Provide credible expert PH leadership to the GMPHN and the wider Greater Manchester system. 3. Influence city-regional and national strategy and policy to shape the building blocks of health and the determinants of health inequalities. 4. Agree the ambitions, delivery plans and investment strategy of the GMPHN. 5. Provide oversight of programme delivery, performance, and outcomes.
Membership
• 10 x Local Authority Directors of Public Health • GMPHN Programme Director
Chair
Chair of the GM Public Health Network
Frequency
Monthly
Quoracy
7 of 10 Local Authority Directors of Public Health must be present for a decision to be binding.

SCHEDULE 3 – FINANCIAL ARRANGEMENTS, RISK SHARE AND OVERSPENDS[1]

1.1 Unless the context otherwise requires, the defined terms used in this Schedule shall have the same meanings as set out in Clause 1 of the main body of the Agreement.

1.2 Subject to any contrary provision in the relevant GMPHN Programme Contract Specification, the Parties agree that Overspends or Underspends shall be managed in accordance with this Schedule 3.

Financial Contributions

1.3 In each of the five Financial Years from 2027/28 to 2031/32 (inclusive), NHS GM will contribute a maximum of £7,800,000 (seven million and eight hundred thousand pounds) per annum to the GMPHN Pooled Fund to fund the Council to deliver the 5-Year GMPHN Action Plan which is to be agreed following completion of this Agreement and which will be inserted at Schedule 1, Part 3 of this Agreement. A detailed 2027-2032 Financial Years GMPHN Pooled Fund Plan will be adopted by the GMPHN Directors of Public Health Group following completion of the Agreement and inserted at Schedule 1 Part 4 of this Agreement.

1.4 NHS GM contributions to the GMPHN Pooled Fund will be paid on a quarterly basis to the Council in April, July, October and January of each Financial Year.

GMPHN Pooled Fund Management

Overspend

1.5 The Partners agree to co-operate fully and apply rigorous financial management to prevent an overspend occurring.

1.6 The GMPHN Pooled Fund Manager will be responsible for identifying a potential overspend at the earliest opportunity. If the GMPHN Pooled Fund Manager identifies an actual or projected overspend the GMPHN Pooled Fund Manager must ensure that the Partnership Board and the GMPHN Directors of Public Health Group are informed as soon as reasonably possible.

1.7 Where a potential overspend is identified by the GMPHN Pooled Fund Manager, the GMPHN Directors of Public Health Group are required to prepare a plan to mitigate and make good the potential overspend and return projected expenditure to a balanced position. The Council shall not be responsible for funding, making good, or be expected to make good, any actual or projected overspend. The mitigation plan will be subject to review and approval by the Partnership Board and may include reducing expenditure in the relevant Financial Year and/or reducing or top-slicing budgets available in a subsequent Financial Year, in accordance with Clause 11.6.

1.8 Where NHS GM is the only financial contributor to the GMPHN Pooled Fund, and is asked to underwrite an overspend, the value of the overspend will be deducted from NHS GM's Financial Contribution in the following Financial Year.

Underspend

1.9 Both Partners enter into this Agreement as a multi-year commitment to delivering long-term programmes of population health improvement. As such, whilst the financial contribution made by NHS GM is identified as annual amounts and broken into quarterly payments, the intention is to create the conditions for the Council as Host Partner of the GMPHN Pooled Fund to invest in GMPHN Programmes which span Financial Years during the term of this Agreement.

1.10 In the event that expenditure from the GMPHN Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, or expenditure

on an individual GMPHN Programme is less than its agreed allocation, the resulting Underspend shall be separately identified and accounted for from the Council's overall financial position. The Partners shall consult with the GMPHN Directors of Public Health Group to develop proposals for its potential carry forward and use in the following Financial Year, consistent with Clauses 11.6 and 11.7.

1.11 Where NHS GM is the only contributor to the GMPHN Pooled Fund, any proposal to carry an Underspend forward from one Financial Year to the next, and any proposed use of that carry forward, must be submitted by the Council as Host Partner, following consultation with the GMPHN Directors of Public Health Group, to the Chief Officer and Chief Finance Officer at NHS GM for review and approval by no later than the end of Quarter 3 in the relevant Financial Year.

1.12 In considering any carry-forward proposal, the Chief Officer and Chief Finance Officer at NHS GM shall have regard to the multi-year nature of NHS GM's investment and the general principle that carry forward should be supported where there is demonstrable evidence that the Underspend is committed within an agreed delivery and financial plan and will be used to improve health outcomes and reduce health inequalities. They may approve all, part or none of the proposal and shall notify the Chair of the GMPHN and the GMPHN Pooled Fund Manager of the outcome by the end of February in the relevant Financial Year.

1.13 Any use of an Underspend carried forward from a previous Financial Year shall be limited to the purpose approved under paragraph 1.13 and shall remain subject to applicable Law and the standing orders and standing financial instructions, or equivalent, of the Partners. Where carry forward of all or part of an Underspend is not approved, NHS GM may require the Council, as Host Partner, to repay the amount not approved. If more than one Partner has contributed to the GMPHN Pooled Fund in the Financial Year in which the Underspend arose, any amount not approved for carry forward shall instead be refunded to the Partners in proportion to their respective Financial Contributions for that Financial Year.

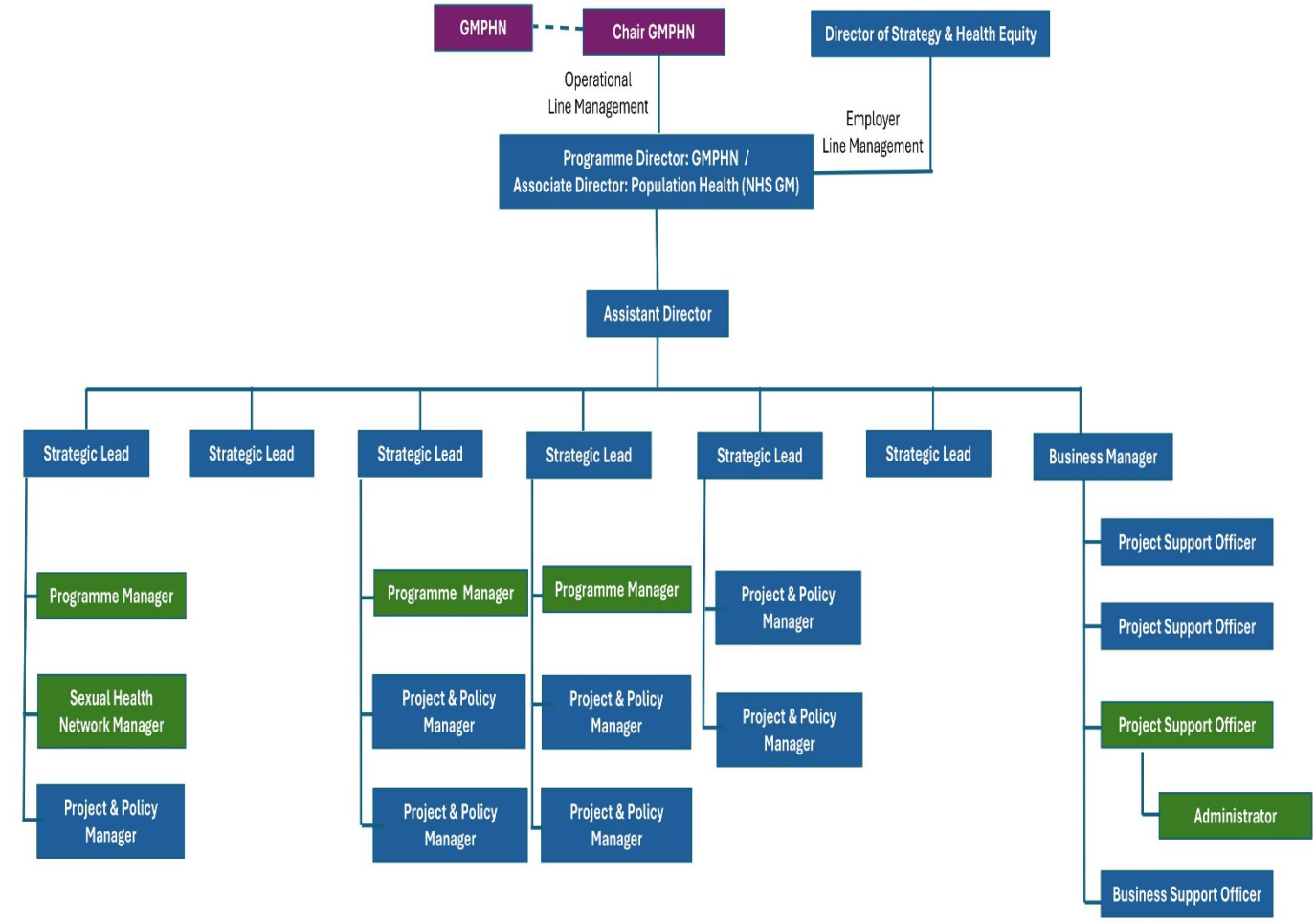
SCHEDULE 4– POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

Throughout the term of this Agreement, NHS GM will act in accordance with its constitution and conflict of interest policies and processes as set out here - https://gmintegratedcare.org.uk/nhs-gm/our-principles/governance/

Any Council member and Council officer on the Partnership Board shall be bound by the principles contained in the Council's Member Code of Conduct and Employee Code of Conduct. If any Council member or Council officer has any pecuniary interest or prejudicial interest in a matter to be considered by the Partnership Board, they must not make any decision on the matter and must leave the room when discussion is taking place on the matter.

SCHEDULE 5 - WORKFORCE AND TEAM ARRANGEMENTS

Transitional Integrated GM Public Health Network Structure 2026/27



Key

NHS GM Staff	NHS GM staff remain on existing terms and conditions
GMPHN Staff (TMBC)	TMBC staff remain on existing terms and conditions, will have a TMBC organisational line manager, and NHS GM day to day supervisor where appropriate

NHS
Greater Manchester

Financial Scheme of Delegation Approval: NHS Talking Therapies Expansion Investment 2026–2029

November 2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

Strategic Commissioning Committee

Wednesday 4th November 2026

Report information.

Required information.	Details.
Title of report.	Financial Scheme of Delegation Approval: NHS Talking Therapies Expansion Investment 2026–2029
Author.	Chris Pimlott - Head of Strategic Mental Health Commissioning
Presented by.	Chris Pimlott - Head of Strategic Mental Health Commissioning
Contact for further information.	Chris Pimlott - Head of Strategic Mental Health Commissioning chrispimlott@nhs.net
Executive summary.	This report seeks approval under the Financial Scheme of Delegation for £5,198,922 to expand NHS Talking Therapies across Greater Manchester from September 2026 to March 2029. The investment funds 28 additional posts, addressing part of the 71-person workforce shortfall identified through the System Maturity Tool review. The staff are already in post, and the investment is expected to increase treatment activity and support improvements in access and performance. The Committee is asked to approve the total scheme cost of £5,198,922.

The benefits that the population of Greater Manchester will experience.	The investment will increase the capacity of NHS Talking Therapies across Greater Manchester, supporting more timely access to evidence-based treatment for adults experiencing anxiety and depression. This is expected to reduce waiting times, improve treatment access and recovery outcomes, and contribute to reducing inequalities in access to psychological therapies. By addressing part of the identified workforce shortfall, the investment will also support the delivery of a more responsive and sustainable service for the population of Greater Manchester.
How health inequalities will be reduced in Greater Manchester's communities.	The investment will increase capacity within NHS Talking Therapies, helping to improve timely access to psychological treatment for adults experiencing anxiety and depression across Greater Manchester. Strengthening service capacity may help reduce inequalities arising from delays in accessing treatment, particularly for communities experiencing greater barriers to mental health support. Improved access to early and appropriate interventions may also reduce the risk of deterioration and support better outcomes across the population.

The decision to be made and/or input sought.	The Board / Committee is asked to: 1. Approve the total scheme cost of **£5,198,922** under the Financial Scheme of Delegation for the expansion of NHS Talking Therapies across Greater Manchester for the period 1 September 2026 to 31 March 2029. 2. Note that the investment is funded through recurrent Service Development Funding and supports 28 additional posts across three providers, with all staff already in post and trained.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	The investment supports NHS Greater Manchester's strategic priority to improve population mental health and ensure timely access to effective, evidence-based treatment. By increasing NHS Talking Therapies capacity, the scheme will help address under-commissioned pathways, improve access and recovery outcomes, and contribute towards reducing waiting times and health inequalities. The investment also supports the mitigation of Board Assurance Framework risks relating to mental health service access, quality and performance, and the delivery of commissioned services. By addressing part of the identified workforce shortfall, it will strengthen service capacity and support improvement against required NHS Talking Therapies performance indicators.

How this aligns to the new strategic objectives.	The investment supports NHS Greater Manchester's strategic commissioning priorities by improving access to mental health services, addressing identified workforce shortfalls and supporting recovery of core NHS services. It contributes to the priorities of targeted action on population health and inequalities, and improving mental health and wellbeing. By increasing NHS Talking Therapies capacity, the scheme is expected to improve access to evidence-based treatment, reduce waiting times and support better outcomes for adults experiencing anxiety and depression. It also supports the wider objective of reducing unwarranted variation in access to care across Greater Manchester.
Key milestones.	• **End of August 2026:** All staff completed their training in preparation for the expansion. • **1 September 2026:** All 28 additional staff commenced in post, with no gap in workforce provision. • **During 2026/27:** Activity, expenditure and performance will be reviewed through existing NHS Greater Manchester commissioning and provider performance arrangements. • **Ongoing:** Treatment activity, access, waiting times and recovery outcomes will be monitored to assess the contribution of the investment towards addressing workforce shortfalls and improving NHS Talking Therapies performance.

Leadership and governance arrangements.	The expansion will be overseen through NHS Greater Manchester's existing commissioning and governance arrangements. Delivery, activity, expenditure and performance will be monitored through contract meetings with the participating providers and reported through the Mental Health Programme Board. The Senior Responsible Officer will provide strategic oversight of the scheme, ensuring that the investment supports the intended increase in NHS Talking Therapies capacity and contributes to improved access and performance. Any significant delivery or financial risks will be escalated through the established commissioning and governance arrangements.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	No specific public or clinical engagement has been undertaken for this financial approval, as the proposal relates to funding additional workforce capacity within existing NHS Talking Therapies services rather than introducing a new service or changing the established care pathway. NHS England undertakes ongoing engagement in relation to the national NHS Talking Therapies programme and its expansion. The investment is informed by the Greater Manchester System Maturity Tool assessment, which identified workforce shortfalls across commissioned services. Financial and performance oversight will continue through existing NHS Greater Manchester commissioning and governance arrangements.

Financial or Legal Implications	**Financial implications** The total cost of the scheme is **£5,198,922** for the period 1 September 2026 to 31 March 2029. The funding is recurrent Service Development Funding allocated for NHS Talking Therapies expansion through the Autumn Statement programme, under funding code 35490N – Mental Health Service Development Funding. The total cost excluding value added tax is £5,198,922, with no value added tax payable. The scheme is included within the reported financial forecast. No savings are attributed to the investment, as underspends against this allocation may be recovered by NHS England. **Legal implications** The proposal relates to additional workforce capacity within existing NHS Talking Therapies services and does not introduce a new service model or care pathway. No specific legal implications have been identified in relation to this financial approval.

Table 1: Information needed about the document and its purpose.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of interest	Report accessibility	EHIA
No	No	No	Yes	No	No	Yes	No

NHS Greater Manchester Integrated Care Board

Expansion of NHS Talking Therapies – Financial Scheme of Delegation Approval

Scheme period: 1 September 2026 to 31 March 2029

Total cost of scheme: £5,198,922

Funding source: Recurrent Service Development Funding – Mental Health, funding code 35490N

1. Introduction

1.1. This paper seeks approval under the Financial Scheme of Delegation for an investment of £5,198,922 to expand NHS Talking Therapies for Anxiety and Depression across Greater Manchester.

1.2. The investment funds 28 additional posts across Pennine Care NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust and Six Degrees. The scheme is funded through recurrent Service Development Funding associated with the Autumn Statement commitment to expand NHS Talking Therapies and covers the period from 1 September 2026 to 31 March 2029.

National policy and funding context

1.3. The Autumn Statement 2023 announced a multi-year investment to expand NHS Talking Therapies, with funding supporting increased workforce capacity and treatment activity through to 2028/29. The national ambition is to increase provision to 915,000 courses of treatment annually by 2028/29, improving access to evidence-based psychological interventions and recovery outcomes.

1.4. The Greater Manchester investment forms part of this phased expansion. A further 28 high-intensity therapists and 8 psychological wellbeing practitioners are anticipated by August 2027 under the wider expansion programme, with continued expansion planned through to March 2029. These additional posts are separate from the 28 posts covered by this approval request.

2. Case for investment and expected benefits

2.1. A comprehensive review of NHS Talking Therapies services across Greater Manchester was undertaken through the System Maturity Tool assessment and associated report. This identified that existing commissioning levels were approximately 71 staff below the minimum workforce requirement for service delivery, with a particularly significant shortfall within the Pennine Care NHS Foundation Trust footprint.

2.2. NHS Greater Manchester is not currently meeting its required NHS Talking Therapies performance indicators. Under-commissioned pathways and insufficient workforce capacity are contributing factors, limiting the system's ability to provide timely treatment and deliver the required levels of activity and recovery.

Proposed workforce investment

2.3. The investment funds the following additional workforce:

Provider	Staffing establishment	Total posts
Pennine Care NHS Foundation Trust	8 Band 7 cognitive behavioural therapists; 3 Band 5 psychological wellbeing practitioners	11

Greater Manchester Mental Health NHS Foundation Trust	14 Band 7 cognitive behavioural therapists	14
Six Degrees	3 Band 5 psychological wellbeing practitioners	3
Total	**22 Band 7 cognitive behavioural therapists; 6 Band 5 psychological wellbeing practitioners**	**28**

2.4. All staff are already in post and completed their training at the end of August 2026. There is therefore no gap in workforce provision associated with implementation. The investment supports the continuation of this additional capacity.

2.5. The expected benefits include increased treatment activity, improved access and waiting times, strengthened low-intensity and high-intensity provision, and a contribution towards reducing the workforce deficit identified through the System Maturity Tool assessment. The investment should also support improvement against national access and recovery requirements, although the extent of improvement will depend on how effectively the additional capacity translates into treatment activity.

Financial summary

2.6. The total cost of the scheme is **£5,198,922**, excluding and including value added tax, as the scheme is exempt from value added tax.

Financial measure	**Amount**
Total cost excluding value added tax	£5,198,922
Total value added tax	£0
Total cost of scheme	**£5,198,922**

2.7. The scheme is funded through recurrent Service Development Funding, under funding code 35490N – Mental Health Service Development Funding. No savings are attributed to the investment, as underspends against this allocation may be recovered by NHS England.

2.8. The scheme is included within the reported financial forecast. The Provider Finance and Insight Mental Health budget is currently forecast to overspend by £15.9 million. The financial submission records a forecast outturn of £1,150.8 million as at August 2026. The investment should be considered in the context of this wider financial position, while recognising that the proposed expenditure is supported by the designated funding allocation.

3. System support and implementation

3.1. The investment supports the delivery of the Greater Manchester NHS Talking Therapies programme by increasing clinical capacity across three providers. The workforce is already in place, and implementation does not require a further recruitment or training phase for the posts included in this scheme.

3.2. Providers will continue to deliver services through existing operational arrangements, with activity, performance and expenditure reviewed during the financial year through established commissioning, finance and provider performance processes.

Monitoring and accountability

3.3. Monitoring will focus on whether the additional staffing resource is generating the expected increase in treatment activity and contributing to improved service performance. This will include review of treatment activity, access and waiting times, recovery outcomes and expenditure against the approved allocation.

3.4. The participating providers will remain responsible for deploying their funded workforce effectively and reporting performance through existing arrangements. NHS Greater Manchester will use this information to assess the contribution of the investment to addressing the identified workforce deficit and improving delivery against required performance indicators.

4. Learning and innovation

4.1. The System Maturity Tool assessment provided a system-wide view of workforce requirements and identified a shortfall of approximately 71 staff against the minimum requirement for service delivery. This demonstrates the value of undertaking a consistent assessment across providers rather than considering workforce requirements in isolation within individual services.

4.2. The current investment applies the findings of that assessment by increasing staffing capacity across low-intensity and high-intensity pathways. The additional workforce provides an opportunity to evaluate how increased capacity affects treatment activity, waiting times and recovery outcomes, and whether the intended benefits are realised across different providers.

Sharing and adopting learning

4.3. Learning from implementation and in-year performance reviews will be considered through existing Greater Manchester commissioning and provider performance arrangements. This will allow the system to identify differences in delivery, understand barriers to translating workforce investment into increased activity, and share effective approaches across participating providers.

4.4. The findings will inform ongoing service planning and future workforce commissioning decisions. This is particularly relevant given the identified workforce deficit and the wider phased expansion of NHS Talking Therapies through to March 2029. Any lessons from the current investment can support future decisions about the distribution of workforce, the capacity required across pathways and the measures needed to improve performance.

4.5. No separate innovation programme is proposed as part of this financial approval. The focus is on using the existing system review, performance information and provider experience to inform continuous improvement and future commissioning decisions.

5. Financial and delivery risks

5.1. If the investment is not approved, there is a risk that the allocated funding will not be used for its intended purpose and may be recovered by NHS England. The existing workforce deficit would also remain largely unaddressed, limiting opportunities to improve access and performance.

5.2. The principal risks are continued under-capacity, delays in accessing psychological treatment, ongoing failure to meet required performance indicators and potential loss of allocated funding through underspend.

5.3. These risks will be managed through the continued deployment of the workforce already in post, in-year monitoring of activity and expenditure, and review of performance through existing commissioning and provider governance arrangements.

6. Conclusion

6.1. The proposed investment of £5,198,922 is a targeted use of recurrent Service Development Funding to expand NHS Talking Therapies across Greater Manchester.

6.2. The System Maturity Tool assessment identified that current commissioning levels were approximately 71 staff below the minimum workforce requirement for service delivery. NHS Greater Manchester is also not currently meeting its required performance indicators in the context of under-commissioned pathways.

6.3. The 28 additional posts funded through this scheme are already in place, with staff having completed training at the end of August 2026. The investment supports the continuation of this additional capacity and is expected to increase treatment activity, improve access and contribute towards addressing the identified workforce deficit.

6.4. Activity, performance and expenditure will be reviewed during the financial year. Learning from the investment will inform ongoing service planning and future commissioning decisions across Greater Manchester.

7. Recommendations

7.1. The NHS Greater Manchester Committee is asked to:

7.1.1. Approve the total cost of scheme of **£5,198,922** under the Financial Scheme of Delegation for the expansion of NHS Talking Therapies for the period 1 September 2026 to 31 March 2029.

7.1.2. Note that the scheme is funded through recurrent Service Development Funding allocated for NHS Talking Therapies expansion.

7.1.3. Note that the 28 additional posts are already in place, staff completed their training at the end of August 2026, and activity and performance will be reviewed during the financial year.

NHS
Greater Manchester

GM HIV Strategy 2026-30

4th November 2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

NHS Greater Manchester Chief Officers

Date – 7th October 2026

Required information	Details
Title of report	GM HIV Strategy 2026-30
Author	David Boulger – Associate Director of Population Health, NHS Greater Manchester.
Presented by	Dr Laura French – Consultant in Public Health, NHS Greater Manchester
Contact for further information	David Boulger – Associate Director of Population Health, NHS Greater Manchester. david.boulger@nhs.net
Executive summary	This report seeks SCC support of the GM HIV Strategy 2026-30 and endorsement for it to be progressed to for formal approval by the NHS GM Integrated Care Board on 4/11/26
The benefits that the population of Greater Manchester will experience.	Approximately 7300 people in GM are living with HIV. This Strategy sets out our roadmap to ending all new transmission of HIV by 2030 and eliminating HIV stigma.
How health inequalities will be reduced in Greater Manchester's communities.	HIV in GM is not a level playing field, with prevalence rates, late diagnosis and avoidable mortality all higher amongst specific population cohorts who are set out in the report. Ending new transmission and eliminating HIV stigma will have a disproportionately positive impact on those communities.
The decision to be made and/or input sought	

	SCC are asked to support of the GM HIV Strategy 2026-30 and endorse its progression for formal approval by the NHS GM Integrated Care Board on 18/11/26
How this supports the delivery of the strategy and mitigates the BAF risks	This strategy sets out proposals which contribute towards our prevention ambitions, the mobilisation of neighbourhood health and live well, and transforming health and care services in line with the 3 transformational shifts set out in the NHS 10 Year Plan.
Key milestones	Co-production: January to September 2026 GM Public Health Network Partnership Group (For Feedback) – 15/9/26 NHS GM CEG (For Feedback) – 29/9/26 NHS GM CDG (For Feedback) – 1/10/26 NHS GM Chief Officers (For Feedback) – 7/10/26 GM Integrated Care Partnership Strategic Board (For Feedback) – 21/10/26 GM Public Health Network DPH Group (For Approval) – 3/11/26 NHS GM Strategic Commissioning Committee (For Approval) – 4/11/26 NHS GM Integrated Care Board (For Approval) – 18/11/26 Launch to correspond with World Aids Day (1/12/26)
Leadership and governance arrangements	The strategy has been co-produced by the GM Fast Track Cities Group and the GM Public Health Network. From an ICB perspective, this is a Population Health programme and, as such, sits under the responsibilities of the Strategic Commissioning Committee. The day-to-day joint SROs for NHS GM are the Associate Director of Population Health (reporting

	to the Chief Officer for Strategy, People and Partnerships) and the Consultant in Public Health (reporting to the Chief Clinical Officer)
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	This Strategy has been co-produced over a period of 11 months by key stakeholders aligned to the Fast Track Cities programme through workshops, meetings and bi-lateral discussions. This has included the GM Public Health Network, Clinicians, ICB Leads, Local Authority Sexual Health Commissioners, VCFSE Sector, and people with lived experience of HIV.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
No	Yes	No	No	No	No	Yes

1. Introduction

1.1 This report seeks Strategic Commissioning Committee support for the draft GM HIV Strategy 2026-30, and endorsement for it being progressed for formal Integrated Care Board approval on 18/11/26.

2. Context

2.1 As a Fast Track City-Region, GM has been a trailblazer in our collective efforts to tackle HIV in Greater Manchester. Due to extensive collaborative efforts, over many decades, most people living with HIV in GM know their HIV status, are engaged in world class treatment and have an untransmittable viral load. This is something to be celebrated but is not a cause for complacency.

2.2 Over the past 1 months, extensive work has been undertaken to co-produce a GM HIV Strategy 2026-30, aligned to the national HIV Action Plan for England, but with an ambition to go further and faster than the national ambition.

2.3 An engagement draft has been subject to significant system review over the past 6 weeks including being presented to GM Public Health Network Partnership Group, NHS GM Clinical Effectiveness and Governance Group, GM Fast Track Cities Partnership, NHS GM Chief Officers and the NHS GM Integrated Care Partnership Strategic Board. It was also shared with a wide range of stakeholders and feedback was actively sought.

2.4 Feedback from the engagement was strongly supportive of the engagement draft of the strategy, with any suggested amendments incorporated into the final version.

3. GM HIV Strategy 2026-30

3.1 The proposed GM HIV Strategy 2026-30 is attached as **Appendix 1** of this report

3.2 The final strategy, building upon feedback received through this engagement phase, will be launched on World Aids Day (1/12/26)

3.3 The draft GM HIV Strategy 2026-30 sets out **3 Strategic Priorities:**

- **Prevent and Test:** We will ensure equitable access to high quality, evidence-based prevention and testing
- **Treat:** We will improve and transform treatment, care and support
- **Thrive:** We will eliminate HIV stigma and discrimination

3.4 These are underpinned by **3 cross cutting delivery principles**:

- **Inequalities**
- **Co-Production**
- **Collaboration**

4. Recommendations

4.1 Strategic Commissioning Committee are asked to:

4.1.1 Support the GM HIV Strategy 2026-30 and endorse its progression for formal approval by the NHS GM Integrated Care Board on 18/11/26

Appendix 1

GREATER MANCHESTER HIV STRATEGY 2026-2030

GREATER MANCHESTER HIV STRATEGY 2026-2030

FOREWORDS

Bev Craig – Mayor of Greater Manchester

"Greater Manchester has a proud history of fighting for equality. We are at our best when we come together, look out for one another and stand up for fairness, dignity and opportunity. That spirit has been at the heart of our response to HIV for decades. Thanks to the determination of people living with HIV, activists, voluntary, community, faith and social enterprise organisations, the NHS and local authorities, we have made real progress in tackling HIV and improving lives. We should be proud of what has been achieved, but we should never be complacent or take that progress for granted.

As Mayor, I want Greater Manchester to be a place that works for everyone: a place where people feel safe, respected and able to thrive. Where nobody is held back from living a full and healthy life. That vision must include everyone affected by HIV. While we have come a long way, too many people still experience stigma, discrimination and unequal access to prevention, testing, treatment and support. Progress has not been experienced equally, and that is why our work is not finished.

This strategy sets out how we will build on the progress we have made and go further. It reflects our shared determination to challenge HIV-related stigma wherever it exists, tackle the inequalities that continue to affect people's lives, and ensure everyone can access the support and treatment they need to live well and thrive.I want Greater Manchester to be a place where nobody is held back by stigma, discrimination or inequality; where people can live healthy, fulfilling lives; and where everyone feels valued, respected and able to contribute. That is the ambition at the heart of this strategy, and one I am proud to champion as Mayor."

Darren Knight - Co-Chair of Greater Manchester Fast Track Cities / Chief Executive, George House Trust

"*As Co-Chair of Greater Manchester Fast Track Cities and Chief Executive of George House Trust, I have the absolute privilege of seeing first-hand the collaboration, commitment, and appetite of people across the system, working together to make sure that we lead the way on the HIV agenda. There are so many people who give their time and lived experience freely to educate and inform people about the realities of living with HIV, and I thank every one of them. We're all working towards ending new diagnoses and ensuring people have the best support to live with HIV.*

However, there's a long way to go. HIV stigma is still rife. At George House Trust we hear every single day about people's experience of HIV stigma and discrimination in places that they should feel safe. HIV stigma prevents people testing, it prevents people even offering HIV tests and it prevents people from living well. HIV stigma and discrimination hold this entire agenda back.

We all have a responsibility to do more, to do it faster and to do it better. Education is key, but so is inclusion. We need everyone to be assured that knowing their HIV status is good for their health

and wellbeing, and that they'll have the support they need whatever the outcome. My hope for this Greater Manchester HIV Action Plan is that it genuinely creates a world where HIV holds no one back."

Dr Orla McQuillan - Co-Chair of Greater Manchester Fast Track Cities / Consultant in HIV and Sexual Health, Northern Sexual Health, Manchester Foundation Trust

"*The Greater Manchester HIV Strategy is critical to ensuring our region builds on the successes we have had already towards HIV Action Plan targets. The strategy provides a clear framework detailing what we need to do locally to successfully achieve our 2030 targets eliminating new transmissions and eradicating stigma enabling people living with HIV to thrive. As a proud HIV Fast-Track region, we have a legacy of unity and action-now more than ever we must come together to make this vision a reality.*"

Gillian McLauchlan - Director of Public Health at Salford City Council and GM Public Health Network Lead for Sexual and Reproductive Health

"*Greater Manchester has a proud history of coming together to tackle public health challenges facing our communities, and our response to HIV is no exception. As Lead Director of Public Health for Sexual and Reproductive Health, I am immensely proud of the progress we have made across Greater Manchester in HIV prevention, testing, treatment and care. This progress has been driven by the dedication and commitment of people and organisations across our city-region. Local authorities, the NHS, community organisations and the voluntary sector have worked tirelessly to improve access to testing, reduce late diagnoses, and ensure that people living with HIV are supported. These achievements have only been possible through partnership and a shared commitment to improving outcomes for our residents.*

While we have made significant progress, there is still more to do. This new Greater Manchester HIV Strategy sets out our collective ambition to eliminate new HIV transmissions and ensure that everyone affected by HIV can live well, free from stigma and discrimination. Behind every diagnosis are people, families and communities. We know that inequalities and stigma continue to impact the lives of people across Greater Manchester, and we must remain unwavering in addressing them. I would like to thank everyone who has contributed to the development of this Action Plan and, most importantly, those who work every day to turn its ambitions into reality."

Professor Manisha Kumar - Chief Clinical Officer at NHS Greater Manchester

"*The strategic vision of NHS Greater Manchester is to create a healthier and fairer city-region by delivering high quality, person-centred care that tackles inequalities and empowers communities. Nowhere is this vision more evident than in the ambitions set out in this Greater Manchester HIV Strategy. It builds on the extensive history that the GM system has spent at the forefront of HIV prevention and care and looks toward a future where the HIV prevention and service landscape is transformed. At a time of great change for the NHS and the health system at large, NHS GM is proud to be a part of the extraordinary network of colleagues working tirelessly to improve access, experience and outcomes for people living with HIV."*

EXECUTIVE SUMMARY

"The difference in being told that you're HIV positive now, compared to when I was told back in 1995 is massive. The difference now is the medication works. The medication is proven. Undetectable equals untransmittable; it's a game changer in learning to deal with your self sabotage, learning to deal with how you feel towards other people and being in society. In 1995 we didn't have this luxury. I was given an AIDS diagnosis and told to get my affairs in order. There was no proven medication and there was no known effective treatment. If you were one of the unlucky ones, that didn't go to one of the charities that were offering support and advice, you never found hope and you never found a light. You never found a reason to wake up the next day, because there was no one there to give it to you. So now, meeting people living with HIV, you know you're going to live"

Anita Binns, Community Activist and Peer Navigator for George House Trust

For more than four decades, Greater Manchester has been at the forefront of the HIV response, and we are confident that we can meet, and go beyond, the ambitions of the new national HIV Action Plan. This will be achieved through collaboration, strong system alignment and by ensuring that lived experience is at the front and centre of our decision-making and delivery.

An estimated 7,300 people are living with HIV in Greater Manchester.

Due to extensive collaborative efforts, over many decades, most people living with HIV know their HIV status, are engaged in world class treatment and have an untransmittable viral load. This is something to be celebrated but is not a cause for complacency.

In Greater Manchester, we aim to go further – ending all new HIV transmissions by 2030, enabling everyone living with HIV to live well and thrive, and eliminating HIV-related stigma.

We believe this is possible if we build upon our existing strengths and use these as a platform from which to push further and faster.

This strategy sets out the steps we will take by 2030 to achieve our ambitions, and establishes 3 strategic priorities:

1. **Prevent and Test:** Ensure equitable access to prevention and improved HIV testing
2. **Treat:** Transform HIV treatment, care and support
3. **Thrive:** Eliminate HIV stigma and discrimination across Greater Manchester

It also recognises that the way we do things matters as much as the things that we do, and commits to three core principles that will underpin every action that we take:

- **Reducing Inequalities**
- **Co-Production**
- **Collaboration**

Working together we can achieve our ambitions.

THE NATIONAL CONTEXT

The national *HIV Action Plan for England 2025–2030* sets out how national, regional and local systems will work collectively to strengthen prevention, testing, treatment and support, reduce stigma, and achieve this ambition through shared accountability and partnership working.

The national plan is structured around five priority areas:

1. **Prevent:** Equitable access to prevention
2. **Test:** Scale up HIV testing
3. **Treat:** Rapid linkage and retention in care
4. **Thrive:** Address stigma and improve quality of life
5. **Collaborate:** Strengthen, and partner across, the sexual and reproductive health (SRH) and wider system

Reducing inequalities is central to the national plan and it prioritises taking additional action to support communities disproportionately affected by HIV, including people experiencing multiple forms of disadvantage. In recognising structural barriers such as stigma, racism, poverty, discrimination, and unequal access to services, the plan supports wider system ambitions to improve inclusion, reduce health inequalities, and improve outcomes for underserved populations.

Whilst acknowledging the need for a universal offer as the bedrock of HIV provision, the plan focuses on 5 key populations who are disproportionately affected by HIV:

- Ethnic minority gay and bisexual men, and all men who have sex with men.
- White gay and bisexual men, and all men who have sex with men.
- Black African heterosexual men.
- Black African heterosexual women.
- Ethnic minority heterosexual adults.

Progress is measured against the UNAIDS definition of ending HIV transmissions, including a 90% reduction in new HIV infections and AIDS-related deaths from 2010 levels by 2030, alongside ensuring the long-term sustainability of the HIV response.

OUR GREATER MANCHESTER CONTEXT

HIV in Greater Manchester

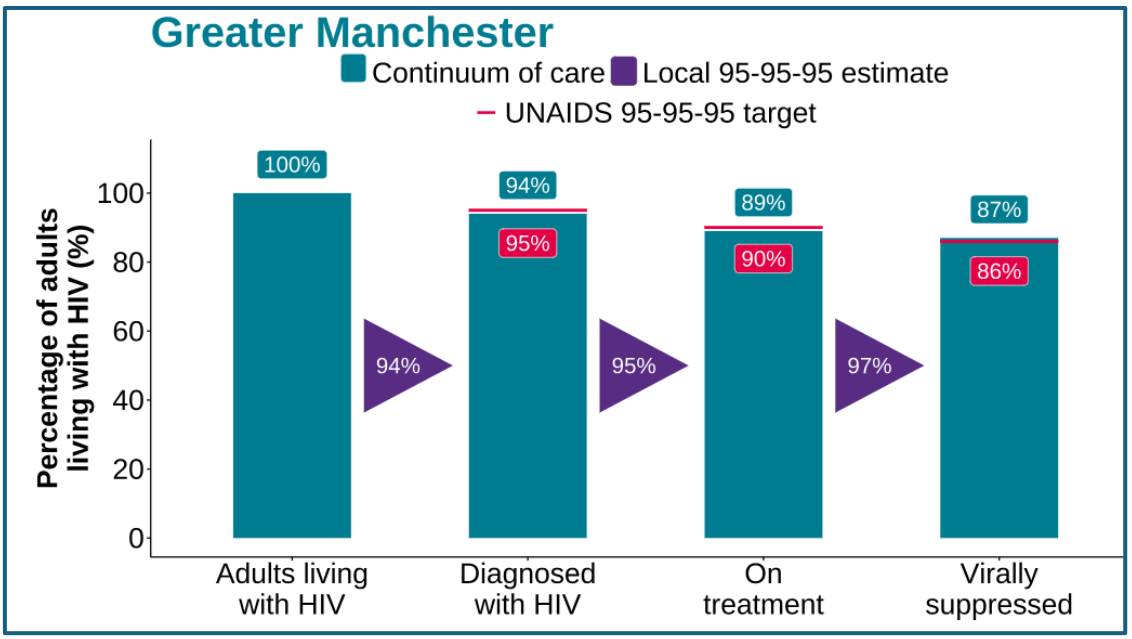
The UK Health Security Agency estimates that 7,300 people in Greater Manchester are living with HIV: 6,900 are diagnosed, 6,550 receive antiretroviral treatment and 6,380 are virally suppressed.

An estimated 254 people who had been diagnosed with HIV were not currently receiving treatment and care, and it is estimated that 400 people living with HIV remain undiagnosed – 5.5% of the total number.

UNAIDS set an ambition that by 2025 95% of people living with HIV should be diagnosed, 95% of people diagnosed should be on treatment and 95% of those on treatment to be virally suppressed.

In Greater Manchester, based on the latest data from 2024, it is estimated that:

- 94% of people living with HIV in Greater Manchester are diagnosed
- 95% of people diagnosed are on treatment
- 97% of those on treatment have a suppressed viral load



New HIV diagnoses among Greater Manchester residents have reduced by 63% since their peak in 2014.

Progress, however, has not been seen equally across all population cohorts with women and people of Black African ethnicity seeing increases in new diagnosis and Gay, Bisexual and all men who have sex with men and people of white ethnicity seeing the greatest reductions.

Our Collaborative Journey

"At the heart of our approach to ending new transmission of HIV has been a longstanding commitment to genuine collaboration and co-production. This has been a transformational journey shared by many people, from many organisations and is an exemplar of what it means to participate in a genuine partnership with our communities and our voluntary, community, faith and social enterprise sector colleagues in a way where lanyards and egos are left at the door and where we are all truly in this together."

David Boulger - Associate Director of Population health at NHS Greater Manchester / Programme Director for the Greater Manchester Public Health Network.

Greater Manchester has been at the forefront of the national effort to end new HIV transmissions and tackle HIV-related stigma, building on a strong legacy of activism and system-wide response dating back to the 1980s.

Our collective efforts over decades have driven improvements, and these have accelerated over the past 10 years and through the designation of Greater Manchester as a Fast Track City.

A timeline included as **Appendix 1** illustrates some of the key achievements and milestones over the past decade.

Highlights have included:

- Launching Greater Manchester's HIVe (Working to End HIV) programme in 2018, with the ambition of ending new HIV transmissions within a generation.

- Becoming a UNAIDS Fast-Track City in 2018, with all ten council leaders and the Mayor of Greater Manchester signing the Paris Declaration—three years ahead of the first national HIV Action Plan.

- Commissioning the Passionate about Sexual Health (PaSH) partnership, led by BHA for Equality, George House Trust, and the LGBT Foundation to drive forward community-led prevention, early intervention and support services.

- The peer-led communications campaign "HIV: Let's Sort This Together" that was instrumental in raising awareness, reducing stigma, and promoting a combination prevention approach.

- Manchester Foundation Trust (MFT) becoming the first hospital trust globally to produce and mandate a "Tackling HIV Stigma and Discrimination" eLearning module which has been completed by over 28,000 members of staff since 2024.

- The Positive Speaker programme run by George House Trust, which is led by volunteers living with HIV who use their own lived experience to educate and inspire others.

- The George House Trust intensive Support Service which provides high intensity dedicated support for people for whom adherence to HIV treatment poses significant challenges.

- BHA for Equality engagement with faith, diaspora and community groups, including the recruitment of community ambassadors and champions, which challenges HIV stigma within ethnic minoritised communities and addresses specific cultural drivers of stigma.

- Providing national leadership on the expansion of Emergency Department (ED) opt-out HIV testing, which was introduced in 2021 and is now operating across eight of Greater Manchester's ten localities, delivering more than 750,000 HIV tests to date, and identifying over 220 people newly diagnosed with HIV and over 140 people previously diagnosed but not accessing treatment and care.

Case studies and testimonies from those involved are included as **Appendix 2**.

OUR CHALLENGES

Whilst significant progress has been made in Greater Manchester, there are challenges to meeting the 2030 targets, many of which mirror those that exist nationally. These can be summarised as stigma, inequalities, late diagnoses, ensuring services are fit for the future, and engagement in treatment and care.

Stigma

> *"There was no judgment and we learnt about something that could affect any of us and now we know not to be scared of it "*
>
> **Pupil, Wright Robinson School**

Despite the existence of effective treatments which provide excellent clinical outcomes, stigma remains the most significant non-medical barrier to ending HIV, negatively affecting mental health and quality of life, reducing the offer and uptake of testing, preventing early diagnosis, creating barriers to equitable healthcare and undermining treatment engagement.

The causes of stigma are complex and multi-faceted and can include:

- Low public and professional understanding of modern HIV treatment and the realities of living with HIV today.
- Cultural shame and a lack of open discourse around issues such as sexuality

- Fear of judgement, and of what a positive result would mean for relationships, family or community standing.

- Negative previous experiences of abuse and discrimination

HIV stigma continues to have significant impact on individuals, communities and the health system in Greater Manchester.

Inequalities

> *"Greater Manchester can be proud of its record on HIV. We also need to recognise that progress has not been shared equally. Success by 2030 will mean that where someone lives, their culture, their gender or their sexuality no longer shape their chances of preventing, diagnosing and living well with HIV."*
>
> **Aydin Djemal, Chief Executive Officer, BHA for Equality**

HIV-related inequalities are stark and significant, reflecting and reinforcing wider structural inequalities, stigma and discrimination.

As an example, new HIV diagnoses among Greater Manchester residents have fallen by 63% since 2014, but these reductions are uneven. From 2019 to 2024:

- Diagnoses decreased by 41.7% among men but increased by 25.6% among women more details on the inequalities experiencing by women set out in the 2025 report, "*Systematically Excluded and Ignored: Addressing Inequalities for Women in the HIV Response*".
- Diagnoses linked to sex between men fell by 64%, compared with a 22% reduction for heterosexual exposure, although gay or bi- men remain the biggest cohort of people living with HIV.
- Among cases with recorded ethnicity, diagnoses are now higher and increasing among Black African residents than White residents where new diagnoses are falling.

One illustrative example of inequalities in access to services relates to the uptake of Pre-Exposure prophylaxis (PrEP), which is a highly effective means of preventing HIV, but whilst 74% of people assessed in GM as having a PrEP need accessed PrEP, this figure was only 23.5% for Black African heterosexual men and 35% for Black African heterosexual women.

Late diagnosis

"Despite progress in testing and work to improve awareness of HIV across the healthcare system, around 40% of people diagnosed with HIV each year in GM are diagnosed at a late stage, already with substantial immune system damage. This can lead to harm including the need for hospital admission, and sadly we still see preventable deaths from HIV. There are often missed opportunities to diagnose HIV earlier, in many areas of healthcare including primary and secondary care. Death from HIV in 2026 should be a "never event", preventable by early testing and treatment. With the changes in testing practice described in this Strategy, we aim to minimise the risk to people with undiagnosed HIV; ensure HIV testing is routine across healthcare in GM and make a real difference to people's health."

Dr Clare van Halsema, Consultant in Infectious Diseases, Manchester University Foundation Trust

Late diagnosis of HIV has significant consequences including increased mortality rates and the risk of onward transmission. Individuals diagnosed at a late stage are five times more likely to die within a year of their diagnosis compared with those diagnosed early, and very late HIV diagnosis increases the risk of early mortality 8-fold and causes significant morbidity with impacts on quality of life.

HIV testing is not consistently available across the full range of healthcare settings in Greater Manchester, as recommended by NICE guideline NG60. As a result, opportunities to diagnose HIV earlier are being missed.

Analysis of late diagnosis reviews, including coronial inquests, suggests that many people have had opportunities to be tested, including testing based on indicator conditions, missed in both primary and secondary care resulting in avoidable harm, including hospitalisation, serious illness and death.

Whilst the proportion of people diagnosed late in Greater Manchester at 39.6% is lower than the proportion in England of 43.3%, it has remained around 40% in recent years without any significant reduction.

Inequalities also exist in relation to late diagnosis:

- Late diagnosis in Greater Manchester is highest for Black African Heterosexual men at 64%, Black African women at 42% and other ethnic minority Heterosexual men at 55%
- The lowest proportion of late diagnosis in Greater Manchester is for ethnic minority gay and bisexual men at 14% and white gay and bisexual men at 31%
- Nationally people over the age of 50 are much more likely to receive a late diagnosis and have a much higher risk of dying from HIV than those diagnosed younger or diagnosed promptly.

Ensuring services are fit for the future

"Around 90% of the population contact their GP practice about their health each year making General Practice a key part of any solution for people who are at risk of, or are living with, HIV in Greater Manchester"

Dr Timothy Dalton, Chair - Greater Manchester General Practice Provider Board, Deputy Chair - Greater Manchester Primary Care Provider Collaborative

The needs of people living with HIV are evolving and changing due to many factors including an ageing population, increasing expectations of digital services and emerging innovations in HIV treatment including longer acting injectable treatments.

Across Greater Manchester there are currently disparities in the range of services and resources available, and a complex set of commissioning arrangements and service delivery arrangements.

For HIV services to be fit for the future, they must be accessible and appropriate for the communities most affected.

For ethnic minoritised communities, this means more than translation — it requires services that actively address racism, cultural bias, and the mistrust that historical and current experiences of discrimination create. Community involvement is central to this work. As HIV services in Greater Manchester are reviewed and transformed, cultural competence must be embedded as a standard, not an add-on. Services that are not accessible to Black African communities — who now account for nearly half of new diagnoses in GM — cannot be considered fit for purpose.

For children, young people and families living with HIV there is a need for tailored, person-centred and non-stigmatising support.

HIV is now a lifelong condition for most people, with effective treatment enabling individuals to lead long, healthy and fulfilling lives. This has led to a growing population of older people living with HIV, many of whom will experience other comorbidities as they age. The ageing population of people living with HIV is likely to bring challenges across the system including a rise in demand on primary care as well as other services associated with ageing like domiciliary care, care homes and housing provision for older people. Meeting the needs of this cohort requires an integrated approach to commissioning and delivery of services across health and social care.

Engagement in Treatment and Care

"Engagement and re-engagement in HIV care must be centred around the individual, understanding the barriers they face and finding solutions that work for them. Across Greater Manchester, collaboration between HIV services, primary care and community organisations enables us to think beyond traditional models of care, with nurses using approaches such as community visits to reach people who may otherwise struggle to access services."

Jen Kendrick - Clinical Nurse Specialist / Team Leader, The Northern Integrated Contraception, Sexual Health and HIV Service. Manchester University NHS Foundation Trust

The latest data indicates that, in 2024, 254 Greater Manchester residents with diagnosed HIV were not accessing treatment or care, with a further 400 people estimated to be living with undiagnosed HIV in Greater Manchester.

Untreated HIV is associated with poorer health outcomes, including an increased likelihood of costly inpatient admissions, as well as a higher risk of onward transmission.

The reasons people disengage from care are often complex and are closely linked to wider health inequalities and factors such as stigma, racism, bias, mental ill health, housing, poverty and substance misuse. For many individuals, these broader determinants are not separate from HIV care; rather, they directly influence whether prevention, treatment, and support services are accessible at all.

The Greater Manchester Emergency Department opt out testing programme has identified over 140 people who have previously been diagnosed but are not accessing treatment and care. Of these, 60% have been linked back into care. By comparison, over 230 people have been newly diagnosed through the programme, with 90% linked to care.

The George House Trust Peer Support programme links individuals to care and where needed provides Intensive Support Workers, who work alongside HIV service multi-disciplinary teams, to identify and support individuals with complex needs and barriers to accessing HIV care.

OUR PLAN: TURNING AMBITION INTO REALITY

OUR GREATER MANCHESTER VISION AND COMMITMENT

Our Greater Manchester vision is to end new HIV transmissions by 2030, enable people with HIV to live well and eliminate HIV related stigma.

Our commitment is to achieve this through the delivery of a whole system, collaborative Greater Manchester action plan, underpinned by the National HIV Action Plan.

OUR PRIORITIES FOR 2026-2030

To achieve our ambitions, we will focus on **3 strategic priorities**:

1. **Prevent and Test:** Equitable access to prevention and improved HIV testing
2. **Treat:** Transforming HIV treatment, care and support
3. **Thrive:** Eliminating HIV stigma and discrimination across Greater Manchester

These ambitions fully align with the national HIV Action Plan, whilst also recognising the relative strengths of our existing approach, our journey to date, and our enhanced level of ambition.

PRIORITY 1: PREVENT AND TEST

Our Commitment

We will act decisively to remove barriers to high-quality, evidence-based prevention and make HIV testing accessible to everyone who needs it.

We will prevent poor health and illness and HIV transmissions wherever possible by ensuring that every person at risk of HIV has equitable access to effective and evidence-based prevention, information, testing and support.

Prevention will increasingly be delivered through trusted community settings, primary care, pharmacies, digital platforms and neighbourhood services, reducing reliance on specialist sexual health services alone.

We recognise that prevention opportunities are not experienced equally. Whilst retaining a universal offer, our approach will prioritise the populations and communities currently experiencing the greatest inequalities in HIV outcomes, by ensuring that prevention is culturally competent, community-led and focused on reducing inequity.

Testing will be normalised and routinely offered across a wide range of healthcare settings, supporting earlier diagnosis and promptly linking those diagnosed to care.

Our Priorities for Action

Working together we will	
1.1	Strengthen community-led prevention with a focus on: • Reviewing the existing HIVe delivery arrangements and identifying opportunities for enhancement

	• Co-producing and delivering campaigns informed by lived experience and community insight • Expanding peer-led and voluntary sector prevention and testing approaches that reach communities less likely to engage with traditional services, including communities who are not being reached under current arrangements.
1.2	Enhance our combination prevention approach bringing together PrEP, condoms, testing, treatment as prevention, behaviour change interventions, formula milk provision, community engagement and peer-led approaches into a comprehensive and coherent prevention offer.
1.3	Complete a review of the current HIV testing offer, barriers to testing and opportunities to enhance the approach across a range of settings, including digital offers.
1.4	Diversify the locations where the delivery of HIV prevention and testing takes place, by increasing prevention and testing activity in trusted community settings and as a feature of Live Well and Neighbourhood Health and enhancing the digital prevention and testing offer.

What Success Looks Like

New HIV diagnoses continue to reduce across Greater Manchester and remain on track to meet the 2030 elimination goal, and inequalities in relation to new diagnoses no longer exist.

PRIORITY 2: TREAT

"Effective HIV Treatment and Care is core to achieving Greater Manchester's ambitions around HIV. We are committed to ensuring that GM residents living with HIV have access to safe and effective HIV care to keep them well and prevent them passing on the virus to others."

Andrew Bibby, Regional Director Specialised Commissioning (North West), NHS England

Our Commitment

We will improve and transform treatment, care and support.

Greater Manchester will be at the forefront of transforming HIV diagnosis, treatment, care and support services and create a modern, integrated and sustainable model of care that delivers outstanding outcomes, enables people to live and age well with HIV, and responds to the changing needs of our population.

We will redesign services around people rather than organisations, strengthening neighbourhood and community-based delivery, while maintaining access to specialist expertise. Through innovation, partnership working and co-production we will ensure services are high quality, equitable, person-centred and fit for the future.

While prevention remains critical to ending HIV transmissions, this action focuses on transforming the services and pathways that treat, support and retain people in care. By creating an integrated and sustainable system, we will improve outcomes, reduce unwarranted variation and ensure everyone living with HIV can access the support they need throughout their lives.

Some elements of this are achievable through short to medium term targeted transformation projects. Others will require a longer-term series of significant and complex transformational system shifts.

Our Priorities for Action

Working together we will	
2.1	Complete a holistic and independent review of the entirety of the current GM HIV model of care (diagnosis, treatment, support, care) and develop proposals to implement improvement and transformational change across the short term (within 1 year), medium term (within 5 years) and long term (5-10 years) that are fully aligned with the 3 transformational shifts included in the NHS 10 Year Plan: Hospital to Community; Treatment to Prevention; Analogue to Digital.
2.2	Work with Primary Care colleagues to review and implement a series of Primary Care "quick wins" with a focus on: • Workforce development • Primary care "HIV champions" • Availability of testing in Primary Care to meet NICE guidance • Creating system prompts for indicator conditions • Strengthening migrant health provision • Embedding HIV testing, diagnosis and treatment into neighbourhood health and everyday support in every neighbourhood.
2.3	Work with specialist HIV treatment and care colleagues to review and implement a series of "quick wins" with a focus on: • Delivering world class care and treatment across GM • Strengthening re-engagement pathways for people diagnosed but not in care • Auditing data completeness and developing actions to improve data quality. • Auditing and reviewing cases where late diagnosis occurs to identify missed opportunities and learning that can drive improvements, potential learning from the GM drug-related death panel approach.
2.4	Strengthen research, data and insight, with an initial focus on: • Working with academic and health innovation partners to establish a GM HIV Centre of Excellence. • Improving data quality, particularly in relation to protected characteristics and socio-economic disadvantage • Introducing a validated HIV-specific Patient-Reported Outcome Measure [PROM] • Producing annual HIV inequalities data profiles
2.5	Work with national government colleagues, to create the system conditions for genuine transformation with a focus on funding, national guidance, service specifications and the locus of control / decision-making.

2.6	Undertake a joint review of the future Social Care needs of people living with HIV to identify the risks and opportunities that exist in relation to an ageing population and those living with co-morbidities.

What Success Looks Like

Late diagnosis of HIV does not occur, services provide treatment and care that delivers excellent health impact, and avoidable mortality from HIV is a "never event".

PRIORITY 3: THRIVE

Our Commitment

Greater Manchester will take a system-wide approach to eliminate HIV-related stigma and discrimination, recognising it as a key driver of inequality and a barrier to prevention, early diagnosis, engagement in care, and quality of life.

Our Priorities for Action

Working together we will	
3.1	Enhance the existing HIV training offer including: • Co-producing a comprehensive HIV Stigma workforce e-learning training package and roll out to all GM NHS, local authority and social care organisations. • Creating a cultural competence training offer co-produced with minoritised and racialised communities and embed it in service standards and commissioning. • Developing a face-to-face learning and training support offer for primary care clinicians and the wider primary care workforce. • Establishing a programme of lived experience led education across Greater Manchester.
3.2	Transform the way we talk about HIV in Greater Manchester including through: • Developing an HIV / Fast Track Cities Communication and Engagement Strategy and Toolkit • Reviewing and renewing the GM PaSH website
3.3	Amplify the voice of lived experience with a focus on: • Conducting community-based research, led by people with lived experience, into the nature and drivers of HIV stigma and with a specific focus on the 5 key populations identified within the national plan. • Undertaking an annual survey of people living with HIV to measure experiences of stigma, and monitoring for improvement.
3.4	Embedding change within organisations, including: • Supporting all GM Hospital Trusts to achieve the HIV Confident Charter Mark and implement the Charter Mark to wider organisations upon a phased national roll out

	• Implementing a GM Blood Borne Virus pledge aligned with the GM Fast Track Cities BBV ambitions and the national HIV Confident Charter Mark.

What success looks like

Greater Manchester will be a place where HIV stigma is actively challenged, where care is consistently respectful, and where people living with HIV are supported to live well free from discrimination.

HOW WE WILL DO IT

THREE CORE PRINCIPLES

The way we do things matters as much as the things that we do, and three Core Principles will underpin everything that we do:

1. Reducing Inequalities

2. Co-Production

3. Collaboration

Reducing Inequalities

Reducing HIV-related inequalities is fundamental to achieving our ambition to end new HIV transmissions, eliminate HIV stigma and enable people living with HIV to live well.

All activities undertaken in service of this Strategy will consider the extent to which they impact upon inequalities, including a specific focus on those populations set out in the national plan, and other people who require additional focus and support such as inclusion health groups, people in prison, and people who face specific barriers to accessing support and treatment, such as people living with a disability.

We will work collectively to ensure that we co-produce culturally competent and inclusive interventions and services, prioritising those communities who experience the greatest barriers and poorest outcomes and recognising that stigma, discrimination, poverty and other structural barriers can lead to unequal outcomes and poor experiences of care and support.

We will use data, intelligence and research to identify priorities, monitor progress and evaluate the impact we have had on reducing inequalities.

Co-production

The Greater Manchester approach to date has been characterised by a genuine commitment to co-production and partnerships with people with lived experience.

We will sustain and amplify that approach and will ensure that all projects, services, communications and interventions are designed with and for the communities most affected by HIV.

Collaboration

Tackling HIV in Greater Manchester is a whole system endeavour, bringing together a wide range of stakeholders all working towards our common goals as a Fast Track City.

This culture of collaboration, humility and mutual trust will continue to form the bedrock of our approach to delivering upon the ambitions set out in this strategy.

CONCLUSION

Our successes to date should not be underestimated. GM has led the way in ending new transmissions and eliminating stigma and we are proud of our achievements.

However, we know we must build on these foundations and go much further if we are to end new HIV transmissions by 2030, enable people with HIV to live well and eliminate HIV related stigma.

This plan provides the roadmap for that journey. Working together we can achieve our ambitions.

APPENDIX 1 – OUR RECENT TIMELINE

- 2013: BHA and LGBT Foundation launch the first community-based HIV point of care testing service across Greater Manchester
- 2017: Passionate about Sexual Health (PaSH) Partnership launched - a unique integrated HIV and sexual health community service for key populations and people with HIV
- 2017-20: GM Sexual Health services participate in PrEP impact trial
- 2018: The NHS in Greater Manchester invested in the HIVe project with an ambition to end new transmissions of HIV in GM in a generation
- 2018: Mayor of GM signed the Paris declaration resulting in GM becoming a Fast Track City
- 2017: Peer support and mentoring commenced
- 2019: Formula milk provision commenced in Manchester
- 2019: The HIVe Programme is launched to accelerate ambitions to reach 2030 goals
- 2019: George House Trust Intensive Support Workers start working directly alongside HIV treatment providers
- 2020: Greater Manchester “HIV: Let’s Sort it Together” HIV campaign launched
- 2020: PrEP commissioned across Greater Manchester
- 2020: BHA and LGBT Foundation launch a digital testing offer for ethnic minoritised and LGBTQ communities
- 2021: Launch of Manchester Foundation Trust Stigma Training Module
- 2021: First national HIV action plan is published
- 2021: Manchester Royal Infirmary commences opt-out HIV testing in its emergency department, and national funding for opt out BBV testing in ED departments announced for areas of very high prevalence
- 2022: First long-lasting injectable treatment for HIV becomes available in Greater Manchester
- 2022: Formula milk provision expanded across Greater Manchester
- 2022: Opt-out ED testing commenced in Wythenshawe and North Manchester General Hospital
- 2023: Opt-out ED testing commenced in Salford Royal Hospital
- 2024: 30th anniversary of LGBT Foundation’s free condom and lube scheme.
- 2024: MFT stigma module made mandatory (more than 28000 staff members have now completed this training).
- 2025: Opt-out ED testing commenced in hospitals in Bolton, Bury, Rochdale, Oldham and Tameside
- 2025: National HIV action plan 2025-2030 launched
- 2025: MFT achieved HIV Confident status

APPENDIX 2 – CASE STUDIES AND TESTIMONIALS

Passionate about Sexual Health (PaSH): Community Action, System-Wide Impact

Across Greater Manchester, trusted community relationships are turning the ambition to end new HIV transmissions into action.

Since 2018, the Passionate about Sexual Health (PaSH) HIVe programme has brought together George House Trust, LGBT Foundation and BHA for Equality, working in partnership with the ten local authorities and the NHS, to deliver community-based HIV prevention where it can make the greatest difference.

Together, they connect people with HIV testing, condoms, PrEP information and wider sexual health support in settings that are convenient, welcoming and culturally responsive.

What makes this approach exceptional is its flexibility. Rather than expecting people to navigate unfamiliar services, PaSH partners take prevention into communities, trusted venues and digital spaces—meeting people where they are and responding to what they need.

High-profile campaigns, including Greater Manchester PrEP Week and Greater Manchester Testing Week, bring this work to life. Alongside national HIV testing campaigns, creative social media activity and trusted influencers help prevention messages travel further, spark conversations and encourage more people to take control of their sexual health.

Some examples of activity delivered by PaSH partners include:

LGBT Foundation: reaching people through trusted LGBTQ+ spaces.

LGBT Foundation works with LGBTQ+ communities and men who have sex with men, providing HIV and STI testing, outreach, condoms and lubricant, sexual health information, and support to access PrEP and PEP. Its venue-based, community and digital outreach connects with people in the places where they already socialise and seek support. A condom programme spanning more than 30 years has distributed millions of free condoms and lubricant, helping to normalise conversations about sexual health. Partnership with Northern Sexual Health also creates a direct community route into PrEP initiation, bridging the gap between engagement and clinical care.

In Action: Connecting People to Prevention and Community Support:

New to Manchester and without family or community connections, AB was experiencing isolation, low mood and low confidence. They contacted LGBT Foundation for a home HIV test and advice about PrEP. Alongside a postal test and PrEP guidance, staff linked AB to LGBTQ+

social groups, talking therapies and immigration advice—providing routes into both healthcare and a supportive community.

BHA for Equality: removing barriers through culturally responsive outreach.

BHA delivers targeted HIV prevention and testing with Black, Asian and other racially minoritised communities across Greater Manchester. Since introducing community HIV testing in 2013, it has supported hundreds of individuals to take their first HIV test and others who may not otherwise access sexual health services. Working through community venues, faith settings, education services, refugee and asylum support organisations and other trusted spaces, BHA tackles stigma, language barriers and limited engagement with traditional healthcare. Testing is combined with condoms, PrEP fast-track referrals, sexual health awareness and wider reproductive health support—turning trusted conversations into practical routes to prevention and care.

In Action: Removing Barriers to HIV Testing

At a British Red Cross hub, BHA supported M—who faced language and booking barriers—to take his first HIV test. Arabic-language information and clear guidance enabled access to further STI testing, condoms and home HIV tests, which he also shared with friends.

In Action: Fast-Tracking Access to PrEP

At a Salford community event, a man with multiple sexual partners who sometimes had condomless sex approached BHA's outreach stall. Unaware of PrEP, he received tailored prevention advice, condoms and an HIV test.

BHA registered him for its Fast Track PrEP pathway, linking trusted community outreach directly to clinical follow-up and widening access to HIV prevention.

"I didn't know there was anything called PrEP, now that I know I will be safe".

George House Trust: providing peer-led support tackling stigma and reducing barriers to care.

George House Trust plays a vital role in Greater Manchester's HIV response by ensuring that people living with HIV can access the information, support and services they need to live well. Through approaches including peer mentoring, counselling, advocacy, welfare support, ageing well programmes and community engagement, the organisation helps individuals navigate both their HIV diagnosis and the wider social challenges that can affect health and wellbeing. Its Peer Navigator and Intensive Support workers, embedded into HIV treatment services multi-disciplinary teams, provide personalised support for people experiencing complex barriers to care, advocating and helping them engage with treatment, access healthcare and community services, and build the confidence and skills needed to thrive. By combining lived experience, peer support and stigma reduction activity, George House Trust strengthens

retention in care, improves wellbeing and helps create the conditions needed to achieve Greater Manchester's ambition of ending new HIV transmissions and stigma while ensuring people living with HIV can lead healthy and fulfilling lives

In Action: From Isolation to Engagement: The Value of Peer Support

Living with a detectable viral load, complex trauma and a history of missing appointments and poor clinic engagement, the George House Trust peer support service was crucial for Ahesha. After years without knowing another person living with HIV, it helped reduce isolation, shame and self-stigma. Having support from someone with lived experience created trust and emotional safety, making it easier for her to talk openly, restart medication, attend appointments and stay connected to care

Together, these services show what is possible when prevention is built with communities, not simply delivered to them. By widening access to testing, increasing awareness of PrEP and creating trusted routes into care, PaSH is reducing inequalities and helping Greater Manchester move closer to its ambition of ending new HIV transmissions—one conversation, one connection and one person at a time.

Routine Testing, and Earlier Diagnosis: Emergency Department Opt-Out Testing

The nationally funded Emergency Department Opt-Out Testing Programme embeds routine HIV, hepatitis B and hepatitis C testing for adults having blood tests across nine Greater Manchester emergency departments. By normalising testing within urgent care, the programme enables earlier diagnosis and treatment, reduces onward transmission and addresses health inequalities.

Since its introduction, the programme has delivered more than 750,000 HIV tests, identified over 220 people with previously undiagnosed HIV and re-identified more than 140 people previously diagnosed but not receiving care in Greater Manchester.

A defining strength is the integration of rapid clinical linkage with peer support and community-based follow-up. George House Trust helps people newly diagnosed with HIV navigate care, access emotional and practical support and remain engaged with treatment, translating diagnosis into sustained improvements in health outcomes.

This programme demonstrates the strategic value of embedding routine testing and integrated support within mainstream clinical pathways: widening access, reaching communities underserved by traditional services and reconnecting people who have disengaged from care.

"Early diagnosis enables prompt access to life-saving treatment, improves long-term health outcomes and prevents onward transmission, while re-engagement with care helps ensure people living with HIV can remain healthy and achieve viral suppression.

The programme demonstrates how innovative, system-wide approaches to testing can reduce health inequalities, support earlier diagnosis and play a vital role in achieving Greater Manchester's ambition of ending new HIV transmissions while ensuring people living with HIV can live well and thrive".

Tom Bills, Project Manager (Blood-Borne Virus ED Opt-Out Testing Programme), Bolton NHS Foundation Trust

Safe Starts, Stronger Families: Free Infant Formula Support

With advances in HIV treatment and care, the number of babies born with HIV has dropped significantly and providing free infant formula is a key intervention which can protect newborns from the small risk of HIV transmission through breastfeeding.

Commencing in 2019 in Manchester, and now available across Greater Manchester, George House Trust's free infant formula milk service gives much-needed reassurance to families, providing free formula, bottle steriliser and feeding bottles up to their newborns 1st birthday. Families access the service through antenatal and HIV clinic referral or through George House Trust's Peer Navigators who signpost into the scheme when they meet people living with HIV in clinic during their pregnancy.

George House Trust provides person-centred support and see every intervention as an opportunity to support people living with HIV to access tools to thrive. Across Greater Manchester, 64% of families accessing the service had not received any type of support from George House Trust before, and 53% continue to engage afterwards, through peer support, groupwork or appointments with Advice and Support Case Coordinators in our Targeted Support team.

Cece's Story

"Becoming a mum is full of decisions and there's endless pressure to always make the right choice. Deciding on how to feed your baby comes with lots of questions. You spend time thinking about how it might affect your bond, their growth and the family dynamic. Becoming a mum with HIV is a whole new chapter of navigating stigma and self-stigma. Feeling like you deserve this less than others plays a huge role on the choices you feel able to make.

People assume that because the guidance now supports breastfeeding that this is automatically the right choice to make. However, growing up with HIV and thinking about the limitations on breastfeeding meant it still didn't feel like a viable choice. Monthly appointments and additional

monitoring felt like a burden. Like another reminder that HIV can often shape experiences you just want to be normal.

Being able to make the decision irrespective of the cost of feeding meant I could have a weight lifted off my shoulders. GHT provide a service that gave me a sense of dignity in my choice. All I wanted most was to be the mum I wanted to be, knowing that I could feed my baby without any worries, extra tests and appointments was the right choice for our family".

From Disengagement to Re-engagement: Manchester Foundation Trust and George House Trust Transforming Access to HIV Care

Re-engagement in HIV care requires flexible, person-centred support that addresses the practical, social and personal barriers behind disengagement.
Across Greater Manchester, HIV services, primary care and voluntary and community partners provide tailored routes back into care, including community support and home visits.

The Manchester Foundation Trust and George House Trust partnership combines clinical care, peer navigation and intensive coordination, using lived experience to build trust, reduce stigma and improve equitable re-engagement.

By bringing together clinical care, peer support and intensive coordination, we can respond to the individual rather than expecting the individual to fit around our services.

This provides and equity led, collaborative and trusted approach built on meaningful, lived experience engagement. It is has demonstrated successful re-engagement, ensuring those at greatest risk are accessing the care and supported they need.

Coordinated Support, Sustained Re-engagement: The George House Trust Intensive Support Programme

George House Trust's Intensive Support Programme provides additional support for people with complex unmet needs who are at risk of poor treatment outcomes or disengagement from HIV care.

Referrals focus on people with a detectable viral load, poor attendance or treatment adherence, risk of hospital admission or onward transmission, and reduced quality of life.

Matthew's story

Matthew, 29, had disengaged from care while experiencing homelessness, mental ill health, substance use and financial instability. He had a high HIV viral load alongside untreated syphilis and hepatitis C.

Coordinated support helped him re-engage with HIV and mental health care, secure housing and financial assistance, and access specialist substance-use services.
By case closure, Matthew had achieved an undetectable viral load, completed treatment for syphilis and hepatitis C, secured stable housing, reduced substance use and was consistently engaging with care, demonstrating the impact of coordinated, trauma-informed support.

Ageing Well with HIV: Connection, Confidence and Independence

As HIV treatment has improved, people living with HIV are living longer, healthier lives, and more than half of people living with HIV are now aged 50 or over. This changing demographic is increasingly important in Greater Manchester, where services need to respond to a growing population ageing with HIV and the additional health, care and social needs that can accompany later life. George House Trust's Ageing Well service provides one-to-one support, peer and social opportunities, health and wellbeing information, skills-based workshops and activities that help people remain connected, independent and confident as they grow older. It also provides HIV awareness training to care homes, domiciliary care providers and other organisations working with older people, helping the wider health and care system become better equipped to support people ageing with HIV.

Lydia's story

Lydia, 63, joined the Ageing Well programme two years ago. Neurodiversity made daily tasks difficult, while shyness, isolation and anxiety affected her mental health. She wanted to move closer to an African community and better cultural provision.
With encouragement from the team, Lydia began attending fortnightly craft sessions, where she formed friendships with other Zimbabwean women.

Longer one-to-one appointments supported her independence and helped her address complex needs, including finding suitable housing closer to her new friends.
Lydia now regularly attends Ageing Well events, welcomes others and says visiting George House Trust is the highlight of her week. Since February 2026, 99% of Ageing Well attendees have reported greater social connection and reduced isolation.

"*Supporting Lydia is a joy. She has gained so much confidence through engaging with Ageing Well and she's a firm favourite amongst other attendees at our skills-based and information sessions.*

Ageing Well isn't just about providing social opportunities and one to one support. It's about seeing a person as an individual, identifying barriers they may face in living a healthy life with

HIV, and through working with project partners in the community and offering person-centred care and support, ensuring we empower that person to live their best life, free from stigma and discrimination."

Anna Hughes, Ageing Well Lead at George House Trust

Changing Minds Through Lived Experience: Positive Speakers

The Positive Speakers project provides HIV Awareness training delivered by a diverse group of trained volunteers who talk about their experiences of living with HIV and answer questions.

Training is delivered to a wide range of settings including health and social care staff, schools, the voluntary sector and staff who are responsible for carrying out opt out testing in Emergency Departments.

Last year 139 Positive Speaker sessions were delivered talking to 5,440 people. 99% of participants said they had improved their knowledge and understanding of HIV

Wright Robinson School Case Study

Wright Robinson is a large secondary school in east Manchester. Each year positive speaker sessions are delivered to those in Year 10. The session includes a presentation about how HIV is transmitted, the latest developments around HIV and how to challenge HIV stigma. A short video of a group of young people born with HIV talking about their experiences is also shown alongside a Positive Speaker talking about their experiences of living with the virus and answering questions.

This has formed an excellent relationship with the staff at the school and in particular the head of PHSE who is has spoken about what a positive learning experience it is for her students, with, 99% saying their knowledge and understanding of HIV had improved.

The responses received from students are also very positive:

- *"There was no judgment and we learnt about something that could affect any of us and now we know not to be scared of it"*
- *"I liked the personal stories as you get a better insight into how people living with HIV deal with it"*
- *"Thanks so much for teaching us! I was looking forward to being educated about HIV because I have never understood it"*

Transforming the Workforce: A System-Wide Approach to Tackling HIV Stigma

As part of Greater Manchester's Fast Track City initiative, Manchester Foundation Trust (MFT) partnered with George House Trust and Dibby Theatre to develop mandatory HIV stigma training. The programme addresses stigma as a barrier to early diagnosis, equitable care and wellbeing, including within healthcare settings.

Launched in 2021 and shaped by the lived experience of people with HIV, the training became mandatory in 2024 after voluntary uptake proved limited. MFT has since trained more than 28,000 staff, embedding HIV awareness and inclusive practice across the organisation.

Evaluation showed substantial improvements: understanding of HIV stigma increased by 25%, confidence discussing HIV care by 34%, and confidence using appropriate language by 36%.

MFT's recognition as an HIV Confident organisation in 2025 demonstrates how a system-wide, mandatory approach can translate lived experience into workforce change and more inclusive care.

Embedding HIV Awareness Across Local Government

Manchester City Council is strengthening its contribution to ending new HIV transmissions and tackling HIV-related stigma. In partnership with George House Trust, it has developed an HIV awareness e-learning module for all staff, embedding accurate knowledge, inclusive practice and compassionate support across local authority services.

The interactive module covers HIV transmission and treatment, Undetectable = Untransmittable (U=U), HIV and the law, and the impact of stigma and discrimination. Video and lived-experience testimony help staff understand how their roles and everyday interactions can create more inclusive workplaces, services and communities.By equipping the whole workforce to challenge stigma and better support residents, the programme demonstrates the strategic role of local government in improving outcomes, reducing inequalities and sustaining progress towards zero new HIV transmissions.

"*For nearly four years now I have sat on Greater Manchester's Fast Track cities board, and it's been my duty to ensure the political support across our city region never wavers in the mission to end HIV stigma in the fight for zero new transmissions by 2030. The work we've undertaken to enhance our training at Manchester City Council came from someone on World Aids Day who whispered to me during a speech from Paul Fairweather that we needed to ensure the work pioneered in partnership with MFT should be taken further. This year, our Public Health team finally deliver on that conversation - and keep the urgency needed in this agenda across the Council itself.*"

Councillor Thomas F. Robinson, Deputy Leader of the Council, Manchester City Council

Learning from Delayed Diagnosis of HIV in Primary Care (Salford)

Colleagues in Salford routinely review incidents of late HIV diagnosis.

A recent review, led by primary care colleagues following a late HIV diagnosis, highlighted numerous areas for learning within General Practice, including the role of cognitive bias amongst practitioners within the assessment of HIV indicator conditions, ambiguity about where clinical responsibility lay within a shared-care framework, and pre-conceived perceptions relating to who is at a "high" or "low" risk of contracting HIV.

These findings have led to improved procedures for the follow up of patients with abnormal results, practice-wide education on HIV testing in primary care, and a focus on normalising and increasing HIV testing regardless of perceived HIV risk profile. The insights have been shared with secondary care colleagues to support wider system improvements aimed at enabling early diagnosis of HIV.

The practitioners involved reflected that they found this to be an enriching experience.

Forward Plan Public Meeting

Area / Item	September	October	November	December	January	February	March	April	May	June
Standing Items										
Apologies for Absence and Quoracy	X	X	X	X	X	X	X	X	X	X
Declarations of Interest	X	X	X	X	X	X	X	X	X	X
Matters Arising, Action Log & Minutes of Last Meeting	X	X	X	X	X	X	X	X	X	X
Forward Plan Review (at end of meeting in preparation for the next one)	X	X	X	X	X	X	X	X	X	X
Governance and Committee Effectiveness										
Terms of Reference Review	X					X				
Review Committee Priorities							X			
Committee Review of Effectiveness							X			
Thematic Areas - Strategic										
Delivery of Mental Health and Well Being Strategy priorities *								X		
Delivery of Clinical Strategy				X						
Maternity						X				
Strategic Commissioning Framework for Neighbourhood Health	X									
Live Well Annual Delivery Plan						X				
Neighbourhood Health Plans 2027/28							X			
5-Year Commissioning Plan Progress and Commissioning Intentions		X						X		
Clinical Portfolio Statutory Reports										
Chief Clinical Officer Report	X	X	X	X	X	X	X	X	X	X
Safeguarding Adults Partnership Annual Report				X						
Health Protection & Outbreak Management - Statutory Responsibilities Update									X	
S7a Public Health Commissioning - Statutory Responsibilities Update				X					X	
Research Annual Report				X						
Caldicott Annual Report					X					
National Quality Strategy	X									
LeDeR Annual Report						X				
Commissioning										
Chief Clinical Officer Report	X	X	X	X	X	X	X	X	X	X
Annual Commissioning Strategy Delivery Plan (including clinical strategy)										
Commissioning Strategy & Intentions	X		X		X		X		X	
All Age Continuing Health Care	X			X				X		
MT Update			X							
PC Comm Group			X							
Procurement Pipeline & Major Commissioning Decisions	X	X	X	X	X	X	X	X	X	X
SEND Inspection Outcome Reports (as and when required)	X	X	X	X	X	X	X	X	X	X
System Reform and Improvement										
Chief System Reform and Improvement Officer Report	X	X	X	X	X	X	X	X	X	X
Integrated Performance and Quality Report	X	X	X	X	X	X	X	X	X	X
Annual Planning (timings subject to national timescales)		X		X			X			
Year End Position of NHS Oversight Framework (NOF)										X
EPRR Annual Assurance & Winter Readiness			X			X				
Digital Strategy Approval (PRC also)				X						
Data Assurance Briefing (PRC also)		X								
Digital and Data Annual Review (PRC also)				X						
Strategy, People and Partnerships (including Population Health)										
Chief Strategy, People and Partnerships Officer Report	X	X	X	X	X	X	X	X	X	X
Population Health Activity & Impact Update covering the full breadth of ICB Population Health Activity		X								
Population Health Investment Standard Feasibility Assessment (February 2027)						X				
GM Prevention Demonstrator Quarterly Update		X		X			X			
Population Health & Inequalities Deep Dive and implication for strategic commissioning and operational planning	X									
GM Public Health Network Transformation	X		X				X			
Socio-Economic Duty: Work to date and next steps										
Public Engagement Annual Report 2025/26		X								
VCSE Engagement Model		X			X					
Other										
BAF and Risk Register - Assurance	X		X		X		X		X	
Place Outcomes Framework and the Governance, Oversight, Accountability and Assurance Framework			X							
Audit Committee follow-up – procurement and commissioning assurance				X						
FSoD for Expansion of NHS Talking Therapies			X							
Mersey Internal Audit Agency Reports (as and when required)	X	X	X	X	X	X	X	X	X	X

Items deferred:
Delivery of Mental Health and Well Being Strategy priorities - deferred from October meeting due to item being taken to Board recently.